Annual Public Hearing: Health Care Cost Trends

Bunker Hill Community College

June 5, 2012

BOROS: I want to make sure that everybody has a chance to speak, and so we're going to try to start promptly at 9:30 with the panel. This is the second day of the 2012 cost trends hearings, so welcome back to Bunker Hill Community College. I'll again thank our hosts here. We had a great day yesterday and tomorrow will be our final day, with a morning of public comments. If you're interested in submitting public comments, please join us tomorrow morning around 8:30 or 8:45 to sign up, and then we'll have opportunities for public comments of up to five minutes per person.

Yesterday, we heard from some public officials, including Governor Patrick, speaking about the challenge and opportunity of cost containment and the context in which we're having these cost trends hearings today. In the afternoon yesterday, we had a great panel on the challenges and opportunities of care integration as a particular strategy towards cost containment. We had a great discussion that was -- really highlighted some of the challenges in the ways that payment systems and

collaborations can address some of those challenges. So I hope that today's panel -- as you can see, we have a wonderful group of people here -- will be in that spirit of taking a hard look at some of these issues and really having some illuminating dialogue about today, the changes in the marketplace and the experience of tiered and limited networks, after the -- and the impact of Chapter 288.

So just as a matter of housekeeping, I'll let you know that there are going to be staff from the Division who are collecting note cards, if you would like to submit questions from the audience. Given the size of the panel, I can't guarantee that we're going to get to any of those questions, but we still would like to solicit those in case we miss some topics that would be of interest to people. We are going to give each panelist about three to five minutes to give some introductory remarks. I believe we have somebody who is going to be doing a timecard for the introductory remarks, so I ask the panelists, please to keep it brief, just because we have so many and we want to make sure that we get to the larger conversation.

Finally, before we get started, I'm going to ask Christina to come down and swear in the panelists as part of this hearing, which she did so well yesterday. After that, I'm going to turn it immediately over to Michael

Bailit, who has joined us to facilitate the conversation today. Christina.

WU: May I have all the panelists raise your right hands. Do you swear that the testimony you are about to give in the matter now at the hearing, will be the truth, the whole truth, and nothing but the truth?

PANELISTS: (answer in the affirmative).

WU: And please identify yourself by raising your hand, if your testimony today is limited for any reason, or if there are any restrictions placed on the capacity in which you testify today, or if you have any conflicts of interest that require disclosure. No. All right, thank you.

BOROS: Thank you. With that, I will turn it over to Michael Bailit.

Multi-Stakeholder Panel with Perspectives on Recent Shifts in the Health Care Marketplace

BAILIT: Good morning everyone, panelists. So this morning, as Áron indicated, we're going to talk about marketplace

trends that are occurring in Massachusetts, and their impact. I'm pleased, we've got a panel of representatives of personal organizations, payers and provider organizations. I'd like to briefly introduce our panel and then we'll have our panel participants give their prepared statements, so in alphabetical order.

Diane Anderson is President and Chief Executive Officer of Lawrence General Hospital. She's served in that position since 2009. Prior to assuming this position, Ms. Anderson served as Senior Vice President of Clinical Operations at Beth Israel Deaconess Medical Center.

Dr. Gary Gottlieb is President and CEO of Partners HealthCare. He's a Professor of Psychiatry at Harvard Medical School and previously served as President of Brigham and Women's Faulkner Hospitals, as President of North Shore Medical Center and as Chairman of Partner Psychiatry.

Jon Hurst has served as President of the Retailers Association of Massachusetts, a 3,500 member, statewide trade association, since 1990. He also serves as Chairman of the Board of the Massachusetts Retail Merchants Workers Compensation Group and heads the newly formed Retailers Association of Massachusetts Health Insurance Cooperative,

the first nonprofit, small business, health insurance cooperative authorized in 2012 by the Commonwealth.

Mark Rich is Executive Vice President for Corporate Strategy and Management at Steward Health Care System. In addition to overall strategy, he leads the corporate and business development functions, including acquisition strategy, as well as managed care, contracting and insurance product areas. He previously was Chief Financial Officer of Caritas Christi Health Care System.

Eric Swain is Vice President of Sales and Account Management at UnitedHealthCare of New England. He's responsible for driving market innovation, improving quality and affordability for employers and members, and fulfilling United's mission of helping people in New England live healthier lives.

Mark Waldman has served as Treasurer and Collector for the Town of Wellesley since February of 1998. In addition to those responsibilities, Mark was a founding member and is chair of the West Suburban Health Group, a 16-member, municipal joint purchasing group for health insurance, since its inception in 1990.

Kate Walsh has served as President and CEO of Boston Medical Center since March of 2010. Prior to her appointment, she served as Executive Vice President and

Chief Operating Officer of Brigham and Women's Hospital for five years.

Rick Weisblatt is Senior Vice President for Provider, Network and Product Development for Harvard Pilgrim Health Care. Rick is responsible for all aspects of Harvard Pilgrim's provider network strategy. He also leads Harvard Pilgrim's product strategy, including insurance benefits and related services.

And last, I notice we have four people with W. That's quite unprecedented at these hearings. Jeanne Wyand is a Senior Consultant in Towers Watson's Boston consulting office and practices in the area of employee health and welfare benefits. Among her areas of expertise are the financial analysis and design of health care insurance programs. She's provided consulting assistance to clients in many areas of employee benefits, including health care program design and pricing, vendor procurement, and implementation of new programs.

A very good panel. So I'd now like to ask the panel participants to share a prepared statement, should you have one. We have our timekeeper sitting stage center, so you can see him, with his green circle and his red circle. I'm assuming there's a yellow one too, to warn you when you're in trouble. Why don't we proceed in the same alphabetical

order which I introduced each of you, and so Diane, why don't we begin with you.

ANDERSON: Thank you. Good morning everyone. As President and CEO of Lawrence General Hospital, I'm very happy to be invited back to share our perspective and experiences, since I last spoke at the '09 cost trends hearings, and thank you Commissioner Boros, Attorney General Coakley and your team, for conducting these meetings.

Lawrence General is a high value, high quality regional medical center in the Merrimack Valley. Our primary service area includes Lawrence, one of the poorest cities in Massachusetts, and the Andovers and other towns in the Merrimack Valley, some of the most affluent. There is estimated to be about 40 percent out migration from the area, directly to higher priced teaching hospitals. We're also a disproportionate share hospital, with almost 66 percent of our reimbursement from Medicaid and Medicare. We have some unique features, including a very well regarded family practice residency program, in conjunction with the Greater Lawrence Family Health Center. We're a trauma center, with 75,000 ED visits, making our ED one of the busiest in the state.

As a high quality and low cost provider, we believe we have the right building blocks to be part of the solution for escalating costs of health care. Over the past three years, our strategic plan has focused on expanding primary care and bringing needed specialties to the area. We've added key specialties such as endocrine, angioplasty, GYN oncology, and pediatric specialties. And we have experienced an increase in volume and believe some of this is due to our recent expansion of specialists. As an example, the cost for a patient needing an angioplasty at Lawrence General, is about $10,000, estimated to be about $10,000 less than an academic medical center, with great outcomes and sometimes even with the same physician. We've made substantial commitments to providing the care the community needs, such as our trauma center and level two nursery. We're part of an innovative grant with Elder Services, to create care coaches that follow patients home, to ensure compliance for medications and follow-ups. And together with the health center, we established a medical home onsite, designed to decrease the use of our ED for primary care. To put it very simply, we're doing everything in our power to become leaders in providing access and quality at an affordable cost.

Since I last testified, we have made significant strides to align with our physicians, expand services, focus on quality, and prepare to be an integrated care organization. But however, little has changed with our reimbursement from private payers. The dramatic rate inequities identified by the AG's report in '09 persist. Lawrence General's rates remain in the lowest quartile, and price variation is remaining an unsolved challenge for providers like us. Just to give you an example, if we were paid the statewide average for the three major payers, it would increase our revenue about $5 million every year. We believe strongly that these rate inequities must be remedied before we move to alternative payment methods. Total medical expense for residents of our region is among the lowest in the Commonwealth. A global budget, which is based on our current TME, would be unfair and unsustainable. Ellen Zane's *Globe* op-ed last week, highlighted the variation in total medical expense between suburban and urban dwelling children. She talked about the premiums being relatively the same, and if they are, is there any justification that the doctors who care for kids in well hailed suburbs, should have the same budgets, that are richer than those who care for kids in Lawrence.

The public payer picture is also a concern. We will probably be subject to looming Medicare, Medicaid cuts, and cost based proposals that have potentially significant negative impact to Lawrence General. For instance, the Medicaid managed care plans that make up 9 percent of our volume, are looking for rate cuts of significant proportions. That would mean a potential loss of millions of dollars to us annually. With our existing challenges to continually generate positive operating margins, this would really impact our stability.

We also need much greater transparency and better data on rates, cost, utilization, tiering and quality. Limited networks should be designed based on objective transparent criteria, and as a member of the Governor's quality committee, I will advocate that dollars at risk for quality, should be based on a prospective measurable period, not on data that is two or more years old. All too often quality measures are imposed for future years based on historical data. Changes have been happening in our region at a pace we've never seen before. We are now the only not for profit hospital in the Merrimack Valley, sharing a marketplace with an equity finance, for profit competitor. Competition for physician alignment is very

intense and it's difficult for the have nots to compete with lucrative offers.

We believe that we need to find a way to ensure that critical providers in our commonwealth's health care system, who are low cost and high quality, are encouraged to compete and thrive. There are significant unintended consequences if providers like Lawrence General are destabilized. We are a big part of a solution for health care reform and we could ensure success in providing high quality care at the most efficient cost, in addition to managing the population health of our communities. Thank you.

BAILIT: Thank you. Gary?

GOTTLIEB: Good morning. I am the President and CEO of Partners HealthCare, and I want to thank you for the invitation to participate on this panel and in this discussion. A lot has changed since we were here last year. Probably everybody on the panel has a somewhat different point of view of how much has changed and in what way, but change in health care has taken hold in this state, with the cost of care really the focus of the current conversation. We're all aware that those costs, over the last decades, have

been crowding out other vital services of our cities and towns, with cutbacks in public safety, education, community service programs, in order to pay for health insurance for employees and retirees continuing to grow. That's why we must work together now to create change.

At Partners, we've been working on developing solutions that will improve the care our clinicians provide to our patients, while also making that care more affordable. We made a commitment to take $300 million out of our system on an annual basis, and that process is well underway. We also voluntarily ripped up some of our existing contracts with insurers, in an effort to pass back $345 million to consumers, in the form of lower health insurance premiums over the next few years. And we're participating with five other organizations in Eastern Massachusetts as a Pioneer accountable care organization, which offers the hope of a better blueprint for our Medicare patients and more cost effective care. And like others, we've moved our commercially insured primary care populations into shared savings paradigms, like the Blue Cross Blue Shield Alternative Quality Contract and similar contracts with other payers.

Caring for populations is a primary focus for us as we move forward. Delivering the right care, in the right

place, and closer to the homes of our patients. We believe that better coordination will lead to improved quality and it will lower the entire cost of our patients complete health care needs, really reducing the total medical expense. We're also investing in new models to better coordinate care, through such innovations as patient-centered medical homes, where evidence is showing improvement in quality, lower cost and increased satisfaction for patients. In the marketplace, there are other meaningful signs of change. Tiered and limited insurance products are becoming more popular. Cities and towns are beginning to realize savings from some of the municipal health care reforms passed by the legislature last year, and there's evidence that these innovations are beginning to ease the burden on consumers by slowing down dramatically, the rate of premium increase, from double digits two years ago to now the low single digits. As we move forward however, we need to be cautious not to place barriers, legislative or regulatory, in the way of progress, so the innovation in the marketplace is not stifled.

And for health care providers, we have to keep our mission at the heart of the conversation, the commitment to our patients, to their families, and to the communities

that we serve. To deliver the best care possible is principle. For us that also means providing care to some of the most complex cases. Those include transfers to our hospitals. One in six of our patients were transferred to the Brigham and to the Mass General, in the hope that we could provide unique, lifesaving care. These are among the sickest patients and they are among the most costly. These transfers also speak to quality in a way that no process measure every could, to the groundbreaking science that is around us and that is signature of this region. We've dedicated ourselves to discovery that will yield the cures of tomorrow, as well as to educating the next generation of health care professionals, so they may carry forward, the lessons learned from the healers of our past and our present, and to continue to commit ourselves to supporting our community and our community health centers.

Partners has made a large investment in 21 community health centers that offer comprehensive care to underserved populations and that will encourage wellness and prevention. We have continued to support and subsidize the great needs that our patients have in the care of mental health and substance abuse disorders. Massachusetts recently marked its sixth anniversary of health care reform. Our state can take great pride in this milestone,

which represented an important piece of social justice, by opening the doors to quality and affordable health care for those who live here. Let's work together, move forward carefully, and do no harm to our vital health care system, the patients it serves, the people it employs, and the research and innovation economy that promote job growth. Thank you.

BAILIT: Thank you Gary. Jon.

HURST: Thank you and good morning. Commissioner, thank you for the invitation, it's great to be here. My name is Jon Hurst. I'm President of the Retailers Association of Massachusetts. We're a statewide association formed in 1918. We have 3,500 members. About 98 percent of those are little mom and pops with one to five locations, averaging about ten employees each. The retail sector itself employs about 17 percent of all jobs, all workers in Massachusetts, so we're a significant force in the economy for profit businesses, but one that probably the industry that is the most competitive on the face of the planet and one that has the tightest margins of any industry. When you think about it, the retail sector competes with the guy across the street, in the next town, in the next state and

on the other end of your smartphone. And consequently, the margins for this for profit industry only average about 2 percent, you know very, very tight, and so costs such as health care costs, have a huge impact of whether you're going to be able to continue to employ people and continue to serve your customers and to expand.

Really, after the passage of Chapter 58, as the economy -- which was really passed at really the height of the economy, and the economy, as we all know, started going in the other direction shortly thereafter, about a year or so after. We started hearing from our small businesses that really were concerned about the increases of their health care premiums. And it was in an environment in which the government required them to provide health insurance and it required their employees to purchase health insurance. It was an issue that we only really heard from our small businesses. We do have a large risk of exempt members, you know national retailers like the Macy's and Wal-Marts of the world, but we didn't hear anything, not a word from them, and it was all from the small members.

We started surveying our members over what was happening with their health care costs, and over the course of the last five years, the average annualized increase in

the premiums was about 14 percent, and that's a lot. And in order to keep those numbers essentially affordable, what a lot of them did was to buy down, first raise co-pays, then go to higher deductible plans, and you know we've been trying to educate them on other factors and helping them as well. So it really was these trends and the difficult economy that back in 2010, we were the only really leader in going after urging the Governor to reject insurance rate increases. Really, an unprecedented action and one that we didn't take lightly as an industry that frankly, believes in markets, believes in consumer empowerment, and really doesn't see a whole lot of need for regulatory intervention. But that was something that we viewed as vitally important, because that trend had to be stopped and there needed to be a line in the sand written and drawn.

We also urged for the passage of legislation that looked at a variety of changes for small group, including limited networks, something that we believe very firmly in, and also the creation of not for profit, small business health insurance cooperatives. Back in January, we were approved by the DOI as one of the first. We've set about creating RAMHIC as we call it, and it isn't just about helping our members and trying to give them more education, more options, lower costs, and making their employees

better consumers and healthier consumers. It's also about having a seat at the table with the health care industry and giving small businesses a voice, not only for our members, but for small businesses and employees of small businesses across the state. We believe as long as we're going to have a law that says everyone must provide health insurance, everyone must buy health insurance, that is really only viable, politically, economically and legally if the health insurance really is affordable, if there are equal opportunities available to employees of small businesses. So we really need to develop a system that empowers the consumer, frankly the consumer rather than the provider, and we need to find ways to control cost and to financially incent individuals to be good consumers and to get healthier; to find the right location for the right procedures and with a good quality, lower cost provider, and also to get healthier, which will also help the greater good.

That's what we're trying to do in the Retailers Association of Massachusetts health insurance cooperative, and ultimately, that is the way that we will be able to sustain this law that says everyone must have health insurance.

BAILIT: Thank you Jon. All right, I'm going to turn to my right now. Mark.

RICH: Thank you. My name is Mark Rich and as said, I'm the Executive Vice President for Corporate Strategy and Development for Steward Health Care. I think many of you know, Steward Health Care, we're just a little sleepy company, haven't been doing much. Steward Health Care is New England's largest community care, integrated provider network, currently encompassing ten hospitals, nearly 3,500 physicians, with about 2,000 of those who contract with us, the majority of those in private practice. We are the state's third largest employer, with 17,000 employees, so we are also a large purchaser of health care and health care insurance in the marketplace.

We are an organization that is characterized by being substantially at risk. Eighty percent of our commercial lives are at risk under global payment systems, with the three major payers and others. We are also characterized by our commitment to community care and keeping care local, and our investment in the capital necessary to rebuild community hospitals and community hospital programs. By the end of this year, we will have deployed somewhere around $400 million in revitalizing community hospitals, in

an effort to match the desire of our patients to stay local, with the desire to receive high quality care.

We are very encouraged to have the opportunity to participate in today's discussion. I think this is a very complex problem. I think we consistently need to resist the urge to make quick decisions and look for fast and expedient solutions, but that doesn't mean that we should stop changing and stop innovating. We are a big believer that innovation will solve a big piece of this problem and lead to sustainable solutions. As Jon just said, we are actually in a partnership with RAM and Fallon Health, where we look to what are the needs of consumers, the purchasers of health, what are the needs of the health insurers, and what can we, as low cost, high quality providers, bring to the table in order to meet those needs. So I'm going to stop here. I'm looking forward to the rest of the comments and thank you very much for the opportunity to be here.

BAILIT: Thanks, Mark. Eric.

SWAIN: Good morning. I'm Eric Swain, Vice President from UnitedHealthCare. I would like to thank the Commissioner for inviting United to participate in this group. I think we bring a unique view of the situation. UnitedHealthCare

has a national footprint, we're a national company but have significant local presence. Nationally, UnitedHealthCare is a Fortune top 25 company. We cover more than 75 million members worldwide. Our family of companies touches nearly every aspect of the health care system. Locally, our local footprint, we cover 350,000 members here in Massachusetts, nearly a million members throughout New England. Our network covers every part of Massachusetts. We have over 20,000 providers in 77 hospital facilities. In addition, we have a working relationship with Harvard Pilgrim here, locally in Massachusetts.

Nationally, we established the United Health Foundation, which is a not for profit organization dedicated to improving the quality and cost effectiveness. Each year, United Health Foundation issues America's health rankings, which ranks state-by-state, the health of each state. This year, Massachusetts ranked number five, which is good news. It means we're the fifth healthiest state in the country, but the information behind it is I think what's important. If you look at what's happened over the last ten years, adult obesity has increased 48 percent, to nearly 24 percent of the adult population in Massachusetts is obese. Diabetes has increased 35 percent. Now, over 7 percent of the adult population in Massachusetts has

diabetes. And despite great gains, nearly 14 percent of the population, or 723,000 people in Massachusetts still smoke. So we have a lot of work to do. And I point this out because I think any solution we talk about, about solving this health care crisis, needs to help people live healthier and I think it needs to include all participants in the health care system, including us carriers, the government, the providers, but most importantly, I think these people are often excluded, that's the members themselves. We need to engage the members with tools, incentives and knowledge, to help them make the right decisions about their health. Thank you.

BAILIT: Thank you. Mark.

WALDMAN: Thank you. I'm Mark Waldman. I'm Treasurer and Collector for the Town of Wellesley, and in that role I am responsible for the procurement of all the health insurance services for the town. And like many municipalities in Massachusetts, Wellesley buys its insurance through a municipal joint purchase group. Ours is the West Suburban Health Group, a municipal joint purchase group that became operational on July 1, 1990, and jointly negotiates and purchases health benefits for all employees, retirees and

their families, of the members. And I have chaired that joint purchase group since its inception in 1990. West Suburban is governed by a board of representatives of each participating governmental unit. One of the unique structures is that each unit pays into the group on a premium basis, but the group is self-insured to each of its health plans. The group consists of 11,633 health plan contracts, which covers over 21,100 covered lives. And again, that is both employees and retirees. Probably most importantly is our annual expenses that run through this group through a trust is $118 million, so we are not a small organization, not a small purchasing group, and we buy all of our insurance through four companies; Blue Cross, Harvard Pilgrim, Tufts and Fallon. Most of it is on a self-insured basis. We do have a few fully insured products still.

As an industry, the municipalities of Massachusetts have tended to lag behind the markets and it has always been a struggle to try and keep up with the innovations, much of what you'll hear, you know the kind of things that the other panel members will be discussing, and a lot of this is due to the constraints of collective bargaining. We are mandated, under state law, to collectively bargain.

Those laws changed somewhat about a year ago, but the basic structure of required collective bargaining still exists.

West Suburban Health Group itself is as much a financial manager, running $118 million, largely on a self-insured basis, as it is a health plan manager. What the group did about five years ago was it devised a structure of health plans. Many of you will know that the municipalities were, and to some extent still are, some of the few remaining employers that still have health plans that have five dollar co-pays. Many are now moving away from that. What West Suburban Health Group did was create a series of plans called rate saver plans, a number of years ago, largely modeled off of what the group insurance commission does and in addition, what they did was they increased co-pays, put co-pays where there weren't co-pays before, and introduced for the time to us, the concept of some tiered network products. West Suburban sponsored these plans. Each individual community within the group then had the option of how were they going to implement it.

In Wellesley's case, we went full-bore and made a commitment that we were going to bargain with all of our employee groups, to switch to these rate saver plans and drop what were the old traditional legacy plans with the five dollar co-pays. It was a struggle. This was prior to

municipal health reform, so we were required to do full-blown collective bargaining with all of our units. We had to buy these changes, which was item one, and then we had to convince our employees that these products were good for them, as good for them. What we ended up with was somewhat of a mixed of some tiered network products and non-tiered network products. We could not convince one company in particular, at the time we were doing this, to offer us a tiered network product. That's since changed but again, because of collective bargaining, you only get so many bites at this apple.

What we found out is that all things being equal, our employees would stay away from, in this case, tiered products, but what we have found largely is that they tend to stay away from change, and that is probably the single biggest challenge with everything that's going to come down the pike in terms of the new product designs and new cost saving features. Yes, they're out there, yes they're available, but as an employer, as a purchaser and as a person and organization responsible for getting our employees involved, that becomes the challenge. We can make all the changes we want, but if the users aren't willing to make that switch, and we continuously see this, that they're not willing to make that switched, they have

to be forced to make the switch. That is the real challenge that we face going forward. Thank you.

BAILIT: Thank you Mark. Kate?

WALSH: Good morning. I'm pleased to represent Boston Medical Center, the largest safety net hospital in Massachusetts and New England, on this panel. Let me begin by describing the patient population we serve, and talk a bit about how health care payment issues affect our institution and similar safety net systems so significantly. A safety net hospital, also known as a disproportionate chair hospital, is one that provides care to a disproportionate number of low income or government supported individuals. Nearly 80 percent of BMC's business is government related, between Medicaid, Commonwealth Care, The Health Safety Net and Medicare. Approximately 50 percent of our patients are low income and rely on Medicaid, Commonwealth Care and The Health Safety Net Care. In fact, as Massachusetts health care reform has greatly expanded insurance coverage across the state, to an average coverage rate of approximately 98 percent, safety net systems like BMC have a much higher than average uninsured rate. BMC's uninsured rate is nearly 11 percent right now today.

Given the unique nature of our patient population, we rely on the Commonwealth and the Federal Government to appropriately reimburse us for the cost of the quality care we provide to low income patients. In particular, we are significantly affected by Medicaid rate and reimbursement policies. BMC has played a major role in the expansion of health care coverage. We converted more uninsured Medicaid -- more uninsured to Medicaid and Commonwealth Care than any other hospital in Massachusetts. We're committed to ensuring that we operate as efficiently as possible, in order to achieve and sustain long-term financial success and position our hospital, our health plan and our associated community health centers, to successfully transition to alternative payment structures and methodologies.

Take a look at BMC's operating expense trends over the last few years and you will see an organization that has taken cost control very seriously. BMC's operating expenses have increased just 2.3 percent in total, from fiscal year 2008 through fiscal year 2012, an average increase of approximately a half a percent a year. And in fact, over the last two years, from fiscal year '10 through '12, Boston Medical Center's operating expenses have actually decreased by 2.19 percent. Yet cost containment

will not keep BMC's doors open and allow us to continue to provide quality care to the underserved population who rely on us. If reimbursement for Medicaid and other low income services are not brought closer to cost, those hospitals and health centers who disproportionately serve low income patients, will continue to struggle for survival.

The low rate of Medicaid payments has a profound impact on the health care delivery system in Massachusetts. The difference is that safety net hospitals like BMC, serve a larger percentage of low income patients and thus do not have the ability to shift that gap in reimbursement to private insurers. The need for cost shifting to private payers, to make up for Medicaid underpayments, has a negative impact on the cost of health care for individuals and businesses across our state, yet BMC and other safety net hospitals are disadvantaged by the low rates we are paid by commercial insurers as well. Privately insured patients account for only about 15 percent of BMC's business. This is a textbook description of no market clout. The result of having such low rate of commercially insured business is evident in the historically low rates paid to BMC for services we provide, compared to our costs, and to the prices paid to other providers with more market leverage. The Attorney General's report has highlighted

those discrepancies over the last two years. While commercial insurance does not represent a large volume of our business, the low rates we are paid contribute to our financial struggles. We strongly believe that payment reform initiatives must address the inequity in payments rates to the lowest paid hospitals in the state, and not lock in those inequalities to the base rates as we move toward alternate payment systems.

Let me conclude by reinforcing Boston Medical Center's position, that we are dedicated to controlling and reducing the cost of care we provide, even as we work diligently to continuously improve the quality of care we provide. Working with Boston Health Net, our network of community health centers and Boston Medical Center Health Net plan, our hospital can lead the way to more coordinated, patient-centered and affordable care.

BAILIT: Thank you Kate. Rick.

WEISBLATT: Thank you. Thanks to the Commissioner for the opportunity to speak at this important hearing. Harvard Pilgrim is one of New England's leading not for profit health plans, with over a million members in this region. I'm the Senior Vice President for Product and Network, and

we remain fully committed to being part of the solution of a sustainable, accessible, high quality health care system in the Commonwealth.

The last few years have seen relatively low increases in medical trend, with corresponding, very low premium rate increases. Medical trend in '09 for us was 5.3 percent, in '10, less than 1 percent, at .6, and 2011 finished around 2.8 percent. We are projecting somewhat of an increase in '12, of about 4 percent. Much of this is due to lower utilization, wherein certain services are actually lower than they were in the previous year. It's unclear to us and most people who think about this, as to how much this is due to the recession that we seem to have not yet emerged from. But also provider price increases have been more moderate, though still often somewhat higher than inflation.

With respect to our relationships with the provider community, we employ a range of payment and collaborative models to improve quality and care coordination, and reduce costs. Our pay for performance program has been in place for over ten years and provides financial incentives for quality, efficiency, and electronic medical record investment. We also have global risk budgets and shared savings programs, with over half of our network, and

there's been a considerable increase in all of these in the past 18 months as we move away from fee for service and develop a range of options, depending on a group's size and ability to manage that risk. More recently, we've begun clinical pilots with key provider partners, on primary care medical homes, a new concept of specialist medical homes, global or episode case rates and complex condition management. Harvard Pilgrim is providing financial and significant in kind support for these pilots.

In terms of products, we've introduced a number of innovative products designed to better align consumers, employers, health plans and providers. By creating limited and tiered networks, that we'll talk more about today I'm sure, we seek to reveal the very real cost differences among providers, where there is no corresponding quality difference. We also introduced a program called SaveOn this year, which provides actual monetary rewards directly to consumers, for making price informed decisions. We have a healthy futures product that incents members to take a health risk questionnaire, work with a health coach on a plan for objective improvements in their health status, and to do so in active collaboration with their primary care physician.

Our intent in all of this, in whatever we do, is to create a functioning health care market in the Commonwealth, one where innovation is rewarded not stifled, where consumers have actionable information on quality and cost when making health care decisions, and the incentive to do something with that knowledge. Where providers and health plans compete on value, the best quality at the best price, and where the playing field is level and rewards quality and efficiency rather than size and bargaining power. And we are seeing some progress. We're working collaboratively as we never have before, with those hospitals and physicians who want to showcase their value and gain new business from our products that reward that value. We're seeing employers more willing to engage their employees in health care purchases and their own and their families' health and wellness. We're seeing consumers become more cost conscious and relying less on brand and marketing and more on information and value, and we are seeing physicians practice more thoughtfully, about what tests, surgeries and services really make a difference in diagnosis and treatment.

We've got a long way to go to make accessible quality health care sustainable. The Governor, the Attorney General, the Leaders of the House and Senate have taken the

lead in promoting this new marketplace, by emphasizing innovation, looking to reign in excessive prices and holding the entire system accountable for returning value to purchasers, especially small group. This is no time to get timid. It's time to be bold, as we were six years ago, when we started down this road of health care reform. Thank you.

BAILIT: Thanks Rick. Jeanne.

WYAND: Thank you Michael and thank you for the opportunity to speak on this panel. I will be speaking and my comments will be through the lens of the larger employer. Not only those that are headquartered in Massachusetts, but also those who have employees -- who hire some of their employees who are residents of Massachusetts. Towers Watson is a leading global professional services company, helping organizations improve performance through effective people, financial and management risk. With the 4,000 associates around the world, we offer our clients solutions in the areas of employee benefits, talent management and risk management. Our clients include over 85 percent of the Fortune 500 companies, including many organizations headquartered in the Commonwealth, as well as throughout

New England. We work with major corporations, emerging growth companies, and not for profit institutions, in a wide variety of industries, including health care systems and some of the state organizations. In the employee benefit space, our services include retirement and investment consulting, technology and administrative solutions, and strategy, design and ongoing management of health and welfare benefits.

Towers Watson has extensive health and wellness strategy and design expertise for our clients. We assist our clients with developing long-term strategies, and help them understand the implications of emerging trends such as the recent 2010 health care reform legislation at the federal level, and design tactics to help support their strategies. We are a strong believer in the value of benchmark data to effectively manage the various benefit programs. To that end, Towers Watson has invested significant resources to develop tools and databases to help organizations benchmark its programs to that of its peer group, as well as ensure that the organization is measuring the effectiveness of its vendors and its design tactics. For example, we are the cosponsor of the Towers Watson National Business Group on Health, an annual employer survey on purchasing value, and we also

collaborate with MBGH on the Staying at Work survey which was just recently released.

We are a national leader in the emerging and changing field of direct contracting. We employ over 40 professionals, including physicians, RNs, social workers and pharmacists, on our health management team. With the emergence of patient-centered medical homes and accountable care organizations, which have already been mentioned, we believe there is an exciting market for health care systems, both hospitals and physicians, to enhance their internal health management capabilities and then integrate these services into the delivery of medical care for the community at large. Many of our self-insured clients view their employee populations as ideal learning laboratories, to develop the internal organizational capabilities that will be required to be successful in this changing paradigm.

So while there are many uncertainties, and with the upcoming results of the Supreme Court legislation, there are certainly many opportunities to improve and to more effectively manage our health care costs, through better risk management and the ultimate delivery of that care. Thank you.

BAILIT: Thank you. And I want to thank you all for delivering your opening remarks according to schedule. We're actually not behind, which is a major accomplishment. So, I now want to begin to ask you a series of questions. I've organized them a little bit thematically, so I'm going to start first with some questions that have to do with new insurance product designs and contracting strategies. Because there are so many of you and I'd like to give you all the opportunity to share your perspectives, I want to ask that you give complete but succinct responses, if you can do both.

Rick, I want to start with you. I want to note that Massachusetts health plans have introduced new tiered and limited network products to the commercial market over the past year, and I've got three questions for you. The first is, are your employer customers purchasing these products, what kind of employers are most likely to purchase them, and how have your contracted providers responded to these products when you've gone to negotiate with them?

WEISBLATT: Three questions but a succinct answer.

BAILIT: Mm-hmm. And complete.

WEISBLATT: We have a full tiered product which tiers physicians and hospitals. We have one that will come out in August that just tiers hospitals, and we have a limited network, though it's a very large limited network and only excludes about 30 providers. And they are selling, the limited network is selling particularly with small group. It's doing very well in Worcester, it's doubling in size each month. It's bringing anywhere from 8 to 10 percent of premium savings to those employers, and there's a lot of interest in excitement in that, particularly when people look at the network and realize quite how large that is. What we do -- and we've heard some about price disparities, one of the facts in Massachusetts, is there's actually a lot of compression in the middle, and so you can have a very robust but limited network, by only excluding a few outlier providers.

The tiered network is selling both with mid-size, but especially large employers. A limited network is problematic for them. Often, they want to cover the whole state. We actually offer a tiered network in New Hampshire as well, because we have a fair number of employers that cross that border. So I would say both self-insured and fully insured are looking for those kinds of tiered products. The newer type of tiered one is hospitals

themselves are developing their own tiered product that rewards their own employees for staying within their hospital.

With respect to providers, and I mentioned this a little bit in my opening statement. We have gone out to those providers who are in the first tier of our tiered network or who are in our focus product, a limited network, to look at marketing opportunities. We've developed materials, we're out there talking to chambers of commerce and other employers about the product, about all the services that these hospitals provide, the importance of primary care and community care. I'm speaking to pretty packed auditoriums with these providers as partners, as we describe the product and describe the value that they're bringing to the marketplace.

BAILIT: OK, thank you.

WEISBLATT: You're welcome.

BAILIT: Jeanne, Rick shared that the limited network products are selling maybe better with small employers and the tier networks with large employers. With your large employers,

how are they reacting to tiered and limited network products?

WYAND: I would say it's consistent with what Rick had mentioned. Most large employers are looking at models to help them reduce cost, so just putting in a tiered network for the stake of a tiered network, is not going to be effective. There needs to be a little bit of the show me the money. And I think there is a belief with a tiered network, that it can be a most cost effective, high quality level of care, but the vendors, the health systems, as well as some of the providers, need to be able to demonstrate what some of those cost savings are.

There is an issue, I think with some employers, especially on the finance side of the house, who really wants to reduce their overall health care cost. On the HR side of the house, they don't want to create much noise or much disruption, and with a tiered network, you are going to create noise and disruption, because at some point in time, my provider might not be in that tiered network.

BAILIT: Jeanne, you mentioned that at a corporate level, your company is doing a lot of -- or an increasing amount of

direct contracting work. Is any of that happening in Massachusetts?

WYAND: Some of it is happening in Massachusetts, and I would also throughout the other parts of New England, and it's being done at the physician level, at the hospital level, as well as some of the other ancillary care levels. So yes, there's a fair amount of direct contracting going on right now as we speak. What becomes very interesting is whether or not the administrators, the health plans, will be able to manage these one off type contracts on an efficient basis.

BAILIT: Thanks. Jon, you shared earlier, that the Retailers Association of Massachusetts has introduced, with -- a new limited network product through the cooperative. Mark shared earlier that he had a hard time getting employees willing to change, I think in general he said. So my question for you is, are your members willing to limit their employees and their own choices of providers?

HURST: I think they are. The initial reaction is quite positive, and I think the key to this whole proposal, whether we're doing it through our cooperative or what

other cooperatives do and what the plans will do, is to really give choices to small businesses. Too often for small businesses and their employees, there really haven't been any choices. You go in there to the small business and the owner just picks one plan, and oftentimes they buy up to take care of you know, little Suzie just has to have that particular pediatrician, and you know this plan doesn't include that pediatrician. What we're doing through our cooperative is really -- and through Steward and Fallon, is really, you know five different options, depending on where you live and work. You can choose anything from a limited network, right on through regular standard HMO products, to a PPO, and the employer leaves those decisions to the employee. So what works for one employee may not work for another. You set a defined contribution as the employer and you know, for a particular employee that may not even have a doctor, really it's just trying to comply with the law. The law says you must buy health insurance. The limited network is a great option and they're saving a lot of money, but because that one particular employee in your shop of ten people takes it, doesn't mean that someone else has to take it. The key is to give choices to the employee and all your employees, and really let them buy what works best for them.

BAILIT: And can you share, where are you right now in terms of offering coverage through the cooperative?

HURST: Well, we kicked it off on April 1. We went about this, I guess a little bit differently than what people expected. We really started a discussion with Steward, because we really believe in limited networks as an important market based tool. We started with them, brought in Fallon, and really designed a cafeteria plan, so to speak, that really we felt would work for our demographics. We offered that beginning April 1. What is really going to be more significant is what happens July 1, when we actually have an approved DOI cooperative adjustment factor that will actually offer a discount, whatever plan you take, of those Fallon plans. So again, we're getting out there, we're educating, and you know the key is to let them know that the power is yours and the choice is yours, and we're trying to give small business employees, really a lot of the options that have been there for years with large employers.

BAILIT: OK, thanks. Mark, Jon's limited network makes heavy use of your system. In Steward's written testimony, it

described tiered products, not limited network but tiered products, as ineffective in achieving meaningful reductions in total medical expense growth or improving care coordination over time. I'm interested, particularly in light of the fact that the Legislature right now is considering a bill to make tiering smarter, by tiering at the service level rather than the organization level, why Steward is supportive of limited networks but doesn't believe that tiered networks, either as administered today or perhaps as administered in a smarter fashion, are not effective?

RICH: I think our issue, the point we were trying to make in the written testimony, deals with our -- it's slightly different than as you've stated it. I mean, we believe that tiered networks are in effect, for lack of a better term, transitional. We think that there's a lot of emphasis on regulating tiered networks right now, as if they are the endpoint. I think they need to be regulated as a transitional element. We have some problems with tiered networks, I mean, I think as many providers in the state do. As a large system, we participate in many tiered networks, as tier one or favorable tier, and tier two and tier three providers across the state. The issue for us is

that by and large, tiering and the participating in tiering and the differentiation of the tier, is based solely on individual unit price. And we don't think that individual unit price and the focus on individual unit price, while necessary in the short-term, absolutely necessary as a transitional element, is going to lead to sustainable change and sustainable control of cost over the long-term, because you need to bring in utilization and the number of units. So it's not just the price per unit but it's also the number of units. The number of units comes from care coordination, through the reduction of redundancy in services, through better IT and information sharing among providers, and that in and of itself right now, the tiering and the differentiation of tiers, by and large is based upon price point and doesn't speak to the long-term control or long-term coordination of care.

Let me give you an example. We have institutions that are in tier one in some products or providers, physicians that are -- where a primary care physician might be in tier one. The cardiologist, who that provider works with regularly, because they practice in a different hospital, might be a tier two. So now we're in a situation where we've got a primary care physician who encounters a patient who needs the services of a cardiologist. The cardiologist

is actually tier two, there's an economic barrier based upon price point for the employee, for the patient, whereas primary care physician and that cardiologist are on the same IT platform, they share data, they share care protocols, and in fact overall, the care of that patient might have better outcomes and at a lower cost, but the patient now, we have a barrier, an artificial barrier created by price point, that doesn't speak to that. If we're going to do tiering on total medical expense over a long period of time, which I think is part of the evolution, I think we would be much more willing to embrace that.

BAILIT: OK, thanks. I want to ask a few questions now, having to do with the trend towards global payment. Kate, you shared earlier, BMC's recent success around cost containment. Contracting on a global payment basis, however, will require different and difficult challenges. I want to ask you to describe how Boston Medical Center is transforming itself to manage its patient population under a global payment arrangement with Blue Cross and perhaps with other payers.

WALSH: Sure, thanks Michael. I often say that the transformation from fee for service to global payment is going to be a little less rocky at Boston Medical Center, since the fee for service world hasn't been all that kind to us. I think the approach that we take between our -- the coordination of care between our hospital, our health centers and our health plan, is really key to this. We have a strong health electronic technology backbone that links our hospital and our health centers, which we think is key to reducing unnecessary utilization. So much of the infrastructures in place, you know we've been a patient-centered medical home in many of our primary care practices long before it was fashionable, because we had to be. So I actually think the transition, while it will require additional investment in expense, enhancements to our IT system, increased care management for a population of patients, I think it will be a relatively seamless transition for us.

We have a critical mass of government insured patients, as I said in my opening remarks, so unlike other systems, we're largely dealing with one payer, and I think the ability to be accountable to that payer to deliver higher quality care at a lower cost, I think is something that's within our reach.

BAILIT: Do you think, given the patient population you serve, the capacity that you have to have is different than what it might be for a provider serving a different patient population?

WALSH: It's different. We provide -- that's kind of a softball question. We provide 200,000 translator assisted medical encounters in a year. We can care for patients in 30 languages. We pick our patients up and we get them to clinic and we get them home. So I think there's infrastructure that we've built over the years, that I think will help us transform. In addition, our contract with the state and the Federal Government, through the DSTI program, which is Delivery System Transformation Innovation, actually requires us to meet milestones around projects that we are completing, that will allow us to care for patients and to meet metrics and outcome measures that say not only are we taking better care of those patients from a process standpoint, but actually their health outcomes are improving. So I think we're sort of in the position of embracing reform, because we think it's better for our patients and we believe it will be better for the Commonwealth.

BAILIT: OK. Let me ask one more follow-up, maybe a little less softball. I've observed that in doing work in a number of states on medical home transformation, that safety net providers oftentimes are more challenged with transformation than say a private practice with patients who tend to more often be adherent with whatever instructions they're given by their physicians. The physician population is stable, so it's the same group of people who are working full-time, together for years. Your patient population practice environment is different. Now, those might be some of the reasons why I've seen safety net medical homes struggle more than non-safety net medical homes. But I wonder if you can address that, because it seems to me that there are some greater challenges that you face than another provider organization might face.

WALSH: I think there are some challenges that are greater. I think they're less around the stability of our medical staff. Our faculty have been caring for low income patients, I think choose to come to Boston Medical Center to do the work we do. We have a strong primary care presence on our campus. We do about 250,000 primary care visits every year on our campus. We also have family

medicine, in addition to medicine and pediatrics, which I think creates sort of a stable base of primary care.

I think the challenge comes in the additional personnel needed in a practice, so that every professional in that practice can practice at the height of their license. So, more front desk staff. You know, we reduced our -- I spoke to the fact that we significantly reduced our operating expenses. We did that through freezing positions. So, somebody leaves one of our primary care practices, we do probably a lot more soul searching about whether or not we need to replace that front desk staff, a person that other organizations who can afford to make that commitment. So I think it's a little bit in the upfront cost of reorganizing the care delivery system and resourcing it appropriately so that the physician, nurse, pharmacist, can do the work -- social worker, mental health provider, can do the work they're trained to do, as opposed to a lot of clerical, connecting the dots work that many other people, many health care providers do every day. So there is an upfront resource investment that we struggle to make, but hopefully the DSTI funding will help us achieve.

BAILIT: OK, last question. There are some who believe that -- this is because you're leaving early, so I've got to get my

questions in while you're here. There are some who believe --

WALSH: Not early enough apparently.

BAILIT: And Diane, I'm going to ask you the same question next. There are some who believe that provider organizations won't really make transformational steps unless they assume some financial downside risk, that a shared savings opportunity is a nice motivation but it doesn't really force transformation. I'm interested in your perspective, as you're entering new payment arrangements, on whether you think that is so or not.

WALSH: You know, I think we have already assumed downside risk. If you look at the Medicare pay for performance targets, that we struggled to meet frankly. Diane made the point that they're retrospective. So a 2 percent across the board cut in Medicaid disproportionately affects us because of who we serve. So we missed our readmission payment. We missed the ability to recapture a readmission withhold with 23 readmits that happened in 2009. So I think you know, -- and that was a 2012 penalty. So I think the challenge is real for us and I think it's because of

the concentration of the payer that we -- payer experience we have with Medicaid that I think exacerbates that. So I think we already are experiencing downside risk. I think for safety net systems, the challenge of transformation really isn't in the upside or downside risk. It really is in the resources to do it right. It's making sure that you're not -- you know, I like to say kind of any moron can cut a budget, but it's doing it in a way that sustains the organization, so that it can continue to care for the patients that we serve, and making those relative tradeoffs in a time of decreasing utilization is incredibly tricky.

BAILIT: OK, thanks. Diane, can you clarify, is Lawrence General contracting on a global payment basis with any payers today? It wasn't clear from your earlier comments if that was the case.

ANDERSON: No, we're currently not.

BAILIT: So, anticipating though, that you might be considering that question in the future, there are some observers that worry if provider organizations like yours contract on a global payment basis with providers, but the physicians who make up your organization continue to be paid on a fee for

service basis or on a salary basis with volume incentives, that the provider organization bearing the risk won't succeed. So, I'm interested in your thoughts on how do you internally align incentives so that the hospital and its physicians and affiliated providers are all aligned in terms of fair incentives.

ANDERSON: OK. Well, we are at the beginning stages of this and as I mentioned, we're preparing to be an integrated care organization, and the work that we've done over the past year is to bring together all of our quite disparate physicians groups, with the hospital, together in a PHO sort of relationship, in preparation for being able to share risk. And we have very disparate physician groups. We have, as I mentioned, the large health center, Greater Lawrence Family Health Center, that takes care of the majority of our disproportionate share high Medicaid patients. We have other independent groups and a very large multi-specialty group. So they're all very different, but we know together collectively, that we have to be prepared to take risk together and really with the focus being to keep care local, continue to improve quality and decrease utilization.

So we need to build the infrastructure to do that, and that's an issue where we're working very hard to do that, because we are a disproportionate share, because of everything that you heard as far as reimbursement, both from the government side and the private payer side, our hospital has been low cost for a long time, because we've had to be. So that meant that being able to put in IT systems, the right type of access to data, to effectively manage risk. It just has not been able to happen, so now we have to do that. We are also part of the waiver project, the transformational funds that we hope to receive, it's at risk money, from the Federal Government and the state, and they very specifically -- we have very specific metrics and processes to go through in order to receive those funds that are all about transformation, sharing risk and improving the population.

BAILIT: Rick, I'd like to ask you, because you do contracting, to provide your perspective on a question I've just asked of Kate and Diane, and specifically, one is do you think that provider organizations need to assume downside risk in order to make substantive change in terms of how they operate, and two, what are your perspectives on internal alignment of incentives within provider organizations. So

you might negotiate a shared savings arrangement with a provider or a shared risk arrangement. What do you know of and what do you think about, how that provider organization then turns around and aligns its internal payment steps.

WEISBLATT: Sure. So first, no I don't agree that you have to have downside risk, and the evidence isn't there. You know in the old days, providers got used to living off 90 percent of their cap, because they lost all or part of their withal and negotiated new caps that would allow them to live off 90 percent. So I just don't think it's true that you have to have, or force downside risk on provider groups. But for shared savings to work, and the way we do it, the groups get minimal or no base increase, which is really not sustainable. So the motivation is still there to manage the budget, so you end up with a surplus and you get some sustainable increases. So at least that's our position on shared savings and we'll see how this plays out in the time ahead. We're pretty confident that we will have the attention of the group.

BAILIT: So that's sort of -- I mean not quite downside risk, but there's a downside consequence in your shared savings

approach, to not achieving the shared savings because there's not a large rate increase that takes place.

WEISBLATT: Right. In other words, it looks like a normal business. A normal business is looking for upside opportunity, that's why we go into business. We don't go into business to somehow avoid risk; we're looking for opportunity, so we tried to structure it that way.

With respect to what goes on inside the provider groups, I think it is very important. One of the reasons we have a range and didn't just come out with a risk model only, and even continued to do some fee for service with pay for performance, is that the size of provider groups matter, how they're already functioning matter. We have a number of physician groups in community hospitals that are very lean, have relatively low TME, even when you just for price relativities. And so it's not clear to us that they need to be at risk if they're a primary care center, community hospital center practice and they're doing just fine. We're not looking to interrupt that or complicate their lives by imposing a payment model on them.

But when you go into risk, the infrastructure matters. We are actually investing a couple million dollars in our own informatics department, whose main goal will be to go

out and meet with providers and give them physician specific, service line specific information on how they're doing, to create some benchmarks, to compare off their current performance. We look to see what the physician leadership is in the group, because you don't want physicians shielded from the contract model in which they're operating. You want them to understand what it is, you want it to be transparent and you want to make sure, as much as we can, that they have the information they need to manage to it.

BAILIT: OK, thanks. Gary, can you share what Partners is doing, particularly now that you've got the new Pioneer ACO and new health plan contracts, where you've got a lower budget focus, reimbursement model. What you're doing to internally align payment within your organization.

GOTTLIEB: Sure. It's several things. First, we've been engaged, even before we moved into those contracts, in substantial care redesign. So both to look at specific episodes of care, because we have a large referral base, because we have two academic medical centers, and looking at key conditions that account for a large proportion of the care that we provide, to be able to really leverage

non-hospital utilization, in-home services, substitutes for hospitalization, as well as managing the highest risk populations. Redesigning the primary care base not only focused on evolving and creating requirements to move our primary care base to meeting criteria and certification with patients out of medical homes, but with a specific focus on highest risk populations. The overall philosophy of the way we're trying to manage and align incentives is that in the overall population, about 5 percent of the population consume about 50 percent of the overall care, somewhere, I guess about 1 percent, between 20 and 30 percent and Medicare about 10 percent, for about 70 percent. And we've used some of the experience we have had in managing very high risk Medicare populations, to work on embedding care management, creating registries, and a variety of other elements.

The incentives we've created for our physicians have been multifaceted. One, to be able to focus and to adapt approaches to managing high risk populations. Being able to create accessibility in their practices and demonstrate that accessibility. To be able to also adopt a set of quality measures that have been embedded in all those contracts, so that there's some degree of homogeneity across these contracts, that are a little bit dissident, so

that there's a provider status that's consistent and also consistent with our values, where the overall incentive is not to in any way create barriers to access. Barriers to access, we felt to some extent created some of the major problems that existed the last time we tried this all together as a society, in the 1990s. It also created a polarity between primary care and the specialists and hospitals, and the notion that this set of incentives is to try to bring those pieces together.

BAILIT: What about your specialists, because traditionally they have a very strong volume incentive.

GOTTLIEB: Absolutely.

BAILIT: Where the more you do, the more you get paid. How do you address that in your --

GOTTLIEB: So one, they're a part of the similar incentive paradigm and number two, they are deeply engaged in care redesign, where we hope to be able to move in addition to global payments for the overall population base, to bundle payments and other mechanisms of being able to present ourselves to others who want to purchase care, that allow

us to provide a higher degree of efficiency that targets really, excellence in quality, as well as lower total medical expense for the episode, where we take risk for the episode as well. We want to try to use that for some of the internal ways in which we manage our own populations, with our own specialists, to be able to create that cohesion, as well as ultimately be able to present it to the marketplace.

BAILIT: But even if you have efficient episodes, if you're taking risks, say with CMS for Pioneer. If the episodes are efficient but there are still a lot of them and they are growing in volume, isn't that still a challenge for you under a budget?

GOTTLIEB: No question, and high risk care management will in fact create overcapitalization and some excess capacity, there's little question about it. This, like tiered limited networks, are significant ways in which price sensitivity is putting downward pressure on us in terms of both our accessibility to the marketplace and some aspects of what we've built over a period of time.

BAILIT: So let me follow up on capacity. There are many that believe that large health systems with large inpatient capacity, if they are going to successfully function as integrated organizations, operating under global payment, are going to have to take capacity out of their systems, including specifically inpatient capacity, which is very much at odds with the traditional orientation of a health system that's got a big hospital component. I'm interested in how you and the other hospital representatives here are thinking about that. Are you ready to decrease your inpatient capacity in order to change your orientation towards managing population health?

GOTTLIEB: First, we have to design the care to manage the population health and show ourselves that we can do it in a way that meets quality standards, that meets the accessibility standards that our patients deserve, that meets our mission, our values, and what the expectations of the marketplace are. That would be number one, before we start to de-capitalize. Second, our investments are clearly going to be on trying to keep people in their communities, whether that's in community hospitals or in-home community resources or in primary care base. That ultimately is going to leave excess capacity in places that

we built it. We're going to have to determine whether we can face the market with a high enough degree of efficiency and a high enough degree of quality, that there will still be demand for a similar subset of those services. The market will move in a way in which there is going to be a reduction in inpatient utilization, there's no question about it.

If we just focused on the high risk populations I described, the number -- and we also take risk for those episodes, because if you go back to the episodes, remember, if you take risk for an episode, you're taking risk for readmissions, you're taking risk for inappropriate utilization. You're taking risk essentially, within that episode as a specialist, for any excess use of expensive capital and/or procedure that doesn't promote health at the tertiary prevention side or the secondary prevention side, right? So to some extent, one way or the other, the capital that's been built has been built around the assumption of a set of readmissions and over-utilization, that each of these efforts is going to try to accomplish and reduce it.

BAILIT: Diane, would you be ready to take capacity out of your system if your business changed from filling beds -- and I

know I'm oversimplifying, that's not fair, but from filling beds to managing population health?

ANDERSON: We're counting on some of those patients that aren't going into Boston, staying with us. But I think at the same time, we are already seeing -- we have a very low readmission rate for example, so the admissions that we're -- by improving our coordination of care, we're seeing less admissions or less visits to the hospital for the right reasons, obviously impacts our bottom line. We're literally working with the health center to decrease the use of our emergency department, which is significant, to go directly to them as the medical home, because we know there's a proportion of patients that go to our ED, they're really using it as primary care. So that's something that right now, we get paid for every one of those visits right now, and so we're expecting that we're not going to be, because the goal will be to get them to the right place for care, which will be the medical home. And we believe, that as we increase our ability to keep more of the elective cases and more of the cases that right now are going right down into town that don't need to, it's not a tertiary or quaternary reason, then that will also help offset that.

BAILIT: OK. Gary, I have one follow-up question for you. You've talked about episode based payments. To my knowledge, there's not a lot of that going on in Massachusetts right now, in fact maybe none. And so I'm interested in your perspective on pursuing both episode based payments, or bundle payments as a clinical payment strategy, and population based payments and care for populations at the same time. How do they come together?

GOTTLIEB: They come together very, very well. I mean even the vision of the Affordable Care Act, has them coming together. It's part of why CMMI put on the table, Pioneer, as well as trying to have a number of approaches to being able to do bundles. There's a little bit of stricture to their approach, which makes it a little bit hard to be able to move those pieces. But if one thinks about a system in which there is referral based care, as well as really trying to keep people centered in the front end of care, and that front end becomes responsible to be able to manage the overall risk and the great fragmentation that exists, the only way truly to align the incentives between those people who provide the substantial number of episodes of care and those who are managing populations, is to have episode based payments; either to come from the global and

basically for us to vend to ourselves, internal referral, that's where the easiest experiments occur, and it allows us to create the partnerships between our own primary care base, our in-home and other related services on that specialty care, and then to be able to create an efficiency around that same paradigm and sit with Rick or with Eric, and work specifically on the episodes and referral basis where one can create centers of excellence around those episodes, to be able to create them more efficiently, at a better price and with lower total medical expense than others in the market. That's to some extent, I think the comment that Mark was making, that the focus specifically on transactional individual prices becomes irrelevant as total medical expense, either for an episode or for a population, becomes the relevant measure.

BOROS: Michael, if I might. I'd like to follow up on some of those conversations about risk shifting to providers and flip it a little bit and ask, to the extent that we're shifting risk to providers and we're increasing -- changing the incentives by giving them skin in the game and downside and all of the things that we've been talking about. How does that change the world for insurers and for self-insured plans? So does that change the calculus about what

you do as say a self-insured plan, or does that change your business as an insurer? And then as an ancillary question to that, insurers are under all sorts of regulation by DOI. Are there things that an insurer says, well if I'm taking on less and less risk, should that regulatory regime change. So that's a question to both the self-insured plans and to the insurers on the panel.

BAILIT: So I was going to ask Eric a question next, and I know he's been eagerly waiting, so how about we have him answer that first.

SWAIN: So yeah, absolutely, it could be a changing role as we see this evolve. I think nationally, we see almost all of our contract discussions going on have some form of risk involved in them. I think it's happening slowly. It's probably happening quicker in Massachusetts than probably anywhere else in the country. We are running things from patient-centered medical home pilots to Dartmouth, Brookings, ACOs and Tucson. So we're sort of seeing it all out there and I think it's evolving. I think what will happen over the next couple of years will be interesting to see.

One thing, I mentioned the health rankings in Massachusetts, they're good. Massachusetts also ranks 37th, so very poorly, in preventable hospitalizations. So things like that are interesting for us to look at the data, to figure out what we need to do to wrestle with that. I think we will continue to have a role. I think we're seeing the carriers moving back to maybe being a little bit stricter in decision making. Everyone's calling for waste to be eliminated out of the system. I think in the short-term, I think the carriers will have to take on that role to some extent, even though people don't necessarily want to hear that. And I think, I do agree with Gary that it's important that we, when we look at how we shift our populations, where we send our populations and these tiered networks or narrowed networks, I think the quality is a very important aspect of it.

We've run a program nationally for about eight years now. We'll be rolling it out soon in Massachusetts, but it's based upon -- it's a premium designation, so it's picking the right providers, where we want to send our members to. And what makes it maybe a little bit different is, it's quality first. So the first thing we look at is quality and if the provider doesn't hit the quality metric, we don't even move to the cost, and when we move to cost

it's on an episode basis. So when you start talking about shifting members to the lowest cost providers, it's not always based exactly on what the fee schedule is. It's based upon where we're going to get the lowest episode of care. And then also, this whole idea of getting the sickest members, the sickest 5 percent, getting them out and getting them to the absolute right setting, because you know it's sort of the centers of excellence idea and getting the populations there.

So I think overall, the coming together of all these ideas into one strategy, and that's what -- I think we're at the beginning steps of that.

BOROS: Jeanne, do you want to try to answer?

WYAND: Actually it was interesting that you mentioned that Áron, because I wrote down episode based payments, problem. The issue is, that I think employers have gotten very used to -- on the self-insured side, have gotten very used to seeing all of their own data, to understanding all of their own information, understanding what role they play as an organization, to help improve the risk of their population, because that then ultimately will reduce some of their overall health care costs. At the same time, I think they

truly understand that putting the health care costs into an episode, into an accountable care organization, into a more global cap basis, could in fact be a cost saver for them. But it's going to be a struggle for large employers who are used to seeing all of their individual transaction data, to convert that into a global type cap or an episode type payment. And the concept of just trust us, we will get this right, is not going to work with the large employers, because I think we've been there done that in the eighties and nineties and it didn't work. So there is going to need to be a lot of quantitative information that comes out, from both the insurers, who are doing the contracting, and the providers, who are putting together these packages, to in fact ensure that this is going to be the right market going forward.

I think we'll see more guaranteed increases going forward, which we haven't seen for a long time, and I think that's going to be a little bit of the proof that's going to come back to the large employer. But it's going to be a little schizophrenic I think, in the short run.

BAILIT: Gary, what are your reactions to what Jeanne has just said?

GOTTLIEB: I think part of the challenge -- you had said, I don't see much in the way of bundles in the state. Part of the challenge, and I think that any of the payers could speak to it, as well as us providers, we've been collecting data in a specific way. We never have real time data. We collect data specifically for claims, in a retroactive way, and the claims are fragmented. So even we, as a very large self-insurer, I mean you know, we have a substantial number of people at risk because of being the largest employer in the state, of about 80,000 people who we insure, for our employers and their families and self-insured, to be able to collect -- we have a more sophisticated evaluation of those data, which people like you help us with in an ongoing way, that helps us to inform it, then we're able to get from the payers, and it's going to take changes of all of our systems so that we collaborate in the creation of the right kind of software, to create the right kind of registries. Because I can sit and hammer away in a negotiation with Rick or with the folks at Blue Cross or TAP or someone else, and say please, please, let us try a bundle payment. To some extent, the resistance isn't that they don't want us to try a bundle payment, it's also creating the systems to be able to support, from their

perspective, making those payments, and we have to be empathic to that transition as well.

BAILIT: Áron, does that answer your question? OK. Eric, I want to come back to you with another question, and I want to move the discussion now, to talking about trends in market consolidation and in price variation, which was given a lot of focus the last couple years by both the Division and the Attorney General's Office. I'm interested, from your perspective as a payer, how recent activities in provider group hospital acquisitions have affected the dynamics of your contracting and rate negotiations in Massachusetts.

SWAIN: Well, certainly the more power a provider group has, the -- you know typically, at times the higher the cost can be. So I think we have concern over that, but I think as we were just talking about, we also -- you can't look at just the prices, you've got to look at the quality element of it, you have to look at the episodic care and you have to look at overall, what the outcomes are, to look at the overall cost. So I think there's concern across the entire unit, not just from our carriers, about that, but I'm not going to say that we're totally against it because it's you

know, if the information is sharing better, if there's better outcomes, if there's things like that, that's all a positive.

BAILIT: United recently participated in a national study of commercial claims data, a really large study, and one of the principal findings echoed Division of Health Care Finance and Policy finding, in that it reported that price was driving medical expense trend and not utilization. Are you finding this still to be the case in Massachusetts, as it was reported to be in past years by the Division?

SWAIN: It's been both. Over the past, inpatient and outpatient cost increases have driven it. I think in Massachusetts, we've seen that slow down, as in other states where there's a lot of reform discussions, so it clearly helps us with negotiations and all providers. In Massachusetts, I think we also saw the utilization come down a little bit too. So I think we benefit from both of those here locally and really, mostly throughout New England.

BAILIT: Rick, what's been the impact for you in contracting of the recent consolidation activities?

WEISBLATT: One of the things we're seeing in the market is that when I talk to physicians, they just more and more feel that an independent practice is not tenable. They need a capital partner for the demands of an electronic medical record and so on, and the thought that they're going to set up a small practice, especially in Eastern Massachusetts, just seems less and less viable. So this is not just large systems acquiring. It's also I think, smaller physician groups feeling like they need a partner, and even hospitals. But you know, as Eric was saying, if you're very large, you have a lot of market power, you absolutely have to be in our network, it gives you leverage for price negotiation, and you see that in the price disparity. And it's not going to come away just by going to risk, because most risk contracts, as I think it was Kate who said earlier, are based on a current TME, part of which is of course the price that you're getting for the services that you're providing yourselves.

On the other hand, in some of our negotiations with some of the larger systems, we are still focusing on their component parts, because in our view, like a Steward or a Partners, it's not an ACO, and though they have the infrastructure and the capital to promote ACOs within the

system. Because if you think of an ACO as the physicians and hospital that take care of a cohort of patients, what the systems, if it goes well can do, is provide the infrastructure for their individual hospitals and physician groups, to really operate relatively independently and as an ACO. But we don't have much doubt that we're consolidating into six or seven large provider groups. That will create some upward pressure on rates, but on the other hand may create competitive opportunities across those provider groups that could put some controls on those increases.

BAILIT: So you made an interesting comment that you don't see the large systems as each being an ACO, but in fact as being potentially comprised of multiple ACOs. Is that right?

WEISBLATT: That's my view, yeah. Yeah, because I think if you look back in the original conversation about ACOs, out of Dartmouth, again it was a hospital, their physicians and patients. And so, just since Mark is sitting here, you know Holy Family in Methuen doesn't have a lot to do with Good Sam. What they have in common is the infrastructure that Mark's system can provide. And so we want to work

with Steward and other organizations like that, to support the care that goes on around Holy Family for example; the physicians there keeping the care in the community and so on. The risk contract may go across the entire system but you know, we want to be able to work with those component parts, to have that care coordination be more successful.

BAILIT: So what does it mean for Holy Family to be its own ACO but for there to be a risk contract across the system? In contracting terms, what's the difference?

WEISBLATT: Well that's -- you know, one of the questions earlier today was what view a health plan has inside the functioning of a provider entity. Do the physicians understand the contract, how it's working and so on. So though we have a single risk deal, it gets built up through the component parts. We don't just look at -- you know, Mark doesn't come with a number. We look at each component part and build the cap for the system up. As we're investing in systems, all of the large groups; Atrius, Steward, Partners, want us to be able to report on these individual entities, down to the physician or small group, so they know what's actually going on there. And so that's the work that we're doing, so that there may be a single

contract that gets built up through the component parts, and I think both sides need to be able to support the physicians in their practice, where they rarely feel like they're part of any system. They're generally in their office seeing patients and need support to do that.

BAILIT: So does the footprint of an ACO have to be just one hospital, or if Mark's got two hospitals in Merrimack Valley that are close to one another, can they together be an ACO, from your perspective?

WEISBLATT: Sure, because they're going to be sharing specialists and the like. I'm not trying to say it can only be one hospital. I am saying, you've got a statewide system that doesn't look like an ACO to me, in any definition I've ever seen of an ACO.

BAILIT: Right. Well, this is an interesting topic, because I'm working in another state where there's a large hospital organization that in fact wants to create a statewide ACO that's a network of every provider in the state. So it's an interesting comment. Mark, because you've got a number of facilities, I'm interested in your perspective on what

is an ACO? Is it your entire system or is it components within your system?

RICH: I think this calls into question, we as an industry have a tendency to do this a lot, where we start to obsess about what the definition of ACO is. And we've got -- instead of form following function, we've got form leading function. So I mean, I don't actually differ with anything that Rick said. Whether we're a global ACO with all ten hospitals and 2,100 plus physicians in our network, whatever it is, or we're a series of PHOs that are oriented around facility, I think is largely irrelevant. We're not really trying to get hung up on the definition, and that is one of the worries that we have about legislative reform, that it is starting to be hung up on the definition. What we are is a group of physicians, a very large group of physicians, many of whom want to stay in private practice I think, as Rick said, that is a common theme, but don't have the capital or the infrastructure to take on risk. We've given them a model to participate actively in determining what risk contracts they should be in. They know the parameters. They're in risk contracts with our hospitals. The contracts that we have on a risk basis are across all of our physicians and across all of our hospitals,

primarily because that's the only way, I think Gary alluded to before. You need to have a common platform, so that we can get some efficiencies about what is truly a measure of quality, what should we measure as a system, what do we value as a system in terms of quality outcomes. So having everybody in the same risk contract allows us to create that standard platform.

I think going back, the other piece that's part of our contracting and it was talked about earlier, is we definitely think that physicians and hospitals collectively, need to have both upside and downside potential. We think that there's no doubt -- I've never met a physician or a hospital person, a nurse, in our system in this state, that doesn't think that they want to provide the best quality care to any of their patients. So clinical incentives are aligned. We need to align basically, the financial incentives, and we think the best way to do that is upside, downside risk. So if you go back to the original question, whether we're an ACO or not, we're a system that believes that global payment with a significant infrastructure is in fact the future. If you want to call it an ACO or a series of ACOs, it doesn't really matter to us.

BAILIT: I wonder though, does it matter, at least from the perspective of transparency and accountability? I'm wondering let's say Mark's purchasing and his employees really -- this is just theoretically -- are only going to be served by one of your hospitals. He doesn't really care about the other nine that are far away from where his employees reside. So isn't it relevant, at least from a transparently, accountability perspective, to know the performance of the hospital and its related providers for that reason alone?

RICH: Yeah, but I don't think that what I said differs with what you just said. Rick is absolutely right, the way that we break down data from Harvard Pilgrim or Tufts or Fallon, or even Medicare at this point, because we a Pioneer as well, brings it back to that local entity, that local chapter, and to the extent we have a lot of -- we offer limited products. We have limited products that we are standing behind with some insurance partners and we talk to municipalities and self-insured groups, where we offer that level of data right back to them, so we are transparent. Whether again, that transparency... We're talking about data sharing. I don't even know that we need to intervene what the definition of an ACO is, to be able to share data

in meaningful ways, back and forth with people who purchase our services.

BAILIT: OK. Gary, you've got a few hospitals, so I'm interested in your perspective on the same question. Does it matter, when we're talking about contracting on a population basis and defining units of accountability, whether it's the whole system or whether it's components of the system?

GOTTLIEB: I think we kind of envision it in kind of a step-wise way, with there being patient-centered medical homes, to some extent patient-centered medical villages, where the community hospital is kind of that village that together, it's -- that's a quote from someone else, but together have the ability to keep care as locally as possible. The way that Diane described it, I mean one of the expense problems we do have in this state is the over-utilization of academic medical centers for much in the way of secondary and light tertiary care that doesn't need to go there and that need to be kept either at the local institution or frankly, in a local community, without even using the institution, on an ambulatory or an in-home service.

The challenge is also figuring out all of the interstices and what the scale of the interstices are; whether it's in-home services, remote care, telemonitoring, the IT components and the glue, and then essentially where it's necessary, specialists that don't need -- who you don't want to have to generate massive amounts of provider induced demand as we flip the paradigm and therefore have a smaller number of specialists or sub-specialty components like behavioral health, where the nature of it all being embedded in that local place may not be possible. So there are a couple of levels of accountability and if the notion is that you want to try to align the incentives, it's a little bit more complex. There is a high degree of analysis that needs to take place at the physician and front end level, if that's a patient-centered medical or whatever you call it, together with its community set of resources. But also make certain that the efficiency and the way that tertiary and quaternary care, as well as other non-acute services are used, have a degree of contracting accountability and have downside risk as well. Or you have a degree of risk, that the upside, downside question is more of an insurance question.

One of the issues around shared versus non-shared service is making sure that the insurance entity and the

provider essentially have a shared set of objectives and therefore that underwriting risk and other components stay, are clearly important to the payer in that paradigm.

BAILIT: OK, thanks. I want to come back to provider consolidation for a couple more minutes. Mark, you've been an active purchaser in Massachusetts for many years. From an employer perspective, how do you view consolidation in the marketplace? Do you view this as creating efficiencies that will benefit your employees and their dependents, or do you view it as something that's primarily going to drive up your cost?

WALDMAN: Well, largely right now, I kind of view it as giving me a headache, trying to understand everything that's going on as a simple purchaser. I'm coming from a perspective that three years ago, four years ago, my employees were paying five dollars for a primary care visit co-pay, nothing else, and driving down the Mass Pike and seeing a billboard that says join our plan because we have every doctor on the state, and their mindsets are still largely there. What I need as a purchaser, is I need all of this discussion that's been going on today to finish, to then translate into a product that Harvard or United or Blue

Cross, whoever it may be, is then going to come and offer to us, because it falls on me as the purchaser, to deal on an individual level with my employees and my retirees, and try to explain to them why I'm giving them this new plan. Add do that, the confusion over, we've got a Supreme Court case that may change the landscape this summer and I'm hearing about a House and a Senate version in this state that have some differences, that may or may not even become law. Obviously, everything I'm hearing today, there's a lot of thinking that's been going on irregardless of that.

I guess for me to get engaged as a purchaser, I need to know this stuff is going on, but I need to know -- I can't know what the end product is but I need to know when is this end -- when do I leap into this market? I'm split, I'm a finance guy. I would have loved to have thrown every one of these product designs against the wall and see what worked and what didn't. I got a little burned on tiered networking because it wasn't fully flushed when we put it in place. I only get limited bites at my employees, because of collective bargaining statutes. I don't want to get burned again.

I know I'm not really answering your question but my concern is how far away am I from that, are we from that next big thing? When do I jump back into the marketplace,

because I'm not going to go to the bargaining table and say -- and forget whether it's collective bargaining. I'm not going to go to employees and retirees, who are jittery enough anyways, and say we're going to implement this limited network product today, but you can be assured that two years from now... Forget that, because that doesn't exist any more, because federal law changed and global payments are in place and there's going to be new product designs built around whether Steward is the ACO or whether an individual and Steward. So I don't really know, I don't know any answers.

What I'd love to know as a purchaser and I suspect other purchasers would probably like to know is almost a timeframe thing. I mean I know you guys can't answer when is the Legislature going to finish this debate. Hopefully within the next year or so, but then how long does it take to get a product to market that encapsulates all this theoretical stuff as I understand it, that's currently being discussed. So I'm answering your question Michael, with a question back to this esteemed panel.

BAILIT: Not fair, it's not allowed.

WALDMAN: You invited me, so you should have known, I like to break the rules. So that's where I'm at.

BAILIT: All right. I'd like to go to a last topical area and then review some of the questions from the audience. Right now, both Houses are looking at bills that both speak to indexing cost growth in the future, and so I'd like to get some perspectives on that. Jeanne, the House and Senate have produced bills that attempt to index health care cost growth to the gross state domestic product, or the GDP but at the state level. And I'm interested, will your employer clients be satisfied if their premiums in Massachusetts grow at the general level of the economy?

WYAND: Again Michael, because it's a self-insured market, there's no such thing as premiums in this world. It is the increase in health care costs, and so to the extent that the state is able to tell the provider community and the provider groups that their per unit cost and their utilization, needs to be limited, such that the employer's annual cost increase is capped, yeah I think employers would be very interested in that. I think that's where we're headed in the global cap market and the global cap

perspective, but a premium increase for a self-insured employer isn't a --

BAILIT: Right, right.

WYAND: That doesn't mean anything to an employer.

BAILIT: But if it happens in the insured market, then presumably...

WYAND: If it happens in the insured market, presumably it's going to get shifted over to the self-insured market, that tends to be what happens when states get involved in regulating cost increases at the provider level. Whether it be the federal limitation or a state limitation, it gets shifted over to the private payer in the self-insured market, which I think would be an enormously huge concern for our clients.

BAILIT: So you worry about the legislation.

WYAND: We worry about the legislation. It's in the right direction, we're speaking the right language. Just having

payment reform without having health reform and health risk reform becomes a little tricky.

BAILIT: OK. Jon, what about your members? If these bills come together to some compromise and there's a target set for total medical expense growth, if it's at the rate of the economy's growth is that a win?

HURST: Well look, you know when you look at what has happened over the last few years, we had members that saw -- you know as the economy plummeted, saw their business plummet 40 percent. At the same time, they saw their health insurance premiums going up over the same period, about the same. So yeah, they may not understand it, they may not know what the solutions are, but the general frustration is that the health care industry, particularly because we are all entrapped consumers. Whether we're paying for it with our health insurance premiums or our taxes, it needs to somewhat reflect what the economy is. And you know, I don't think a lot of people would have a whole lot of beef with the industry, as long as they are -- you know, any increase and it reflects what all of us are seeing in our own small businesses, what we're all seeing in our own families, with our income, somewhat reflect that.

Now having said that, I think over the course of the last few years, there was a lot of -- call it what you want, perhaps wealth shift, a lot of increases that you know, maybe we need to look at are there those that need to look at some greater productivities and inefficiencies in order to bring some costs down, and we can do that through some good market type of strategies and trying to send consumers in the right direction. However, in any market, you've got to have -- to protect the consumer, you either need competition, good strong competition, or you need regulation. In the absence of either, the consumer gets hurt. Our feeling is let competition in the marketplace work, set some reasonable standards reflecting the economy, but provide some sort of a hammer for those outliers that don't really want to stick with what the general consensus is.

BAILIT: So what does that mean, set targets and if people exceed the targets? I'm not quite sure I'm following what you're recommending.

HURST: Well you know, if folks aren't consistently hitting those targets, there has to be some sort of resolution to that. Ideally, you do something market based as a hammer,

but in the absence of that... You know again, we supported the Governor's and urged the Governor's action on the insurance premiums a few years ago. That was not something that we took lightly and it happened one time over a course of 20 years. I'm not saying you need to do that year after year after year, but at a certain point, if folks aren't playing by the game and we are all entrapped consumers, entrapped taxpayers who our wealth is being shifted to those folks, there needs to be some sort of hammer, and if we can't do it market-wise, the government has to do it for us.

BAILIT: OK. Kate, you're still here, so you get another question, and I'll note that this is in the context of you not getting large Medicaid rate increases every year. But still, if you are given an index in terms of growth in total medical expense for your covered population, across lines of business, and the index is the gross state product, is that something you can manage to?

WALSH: I think we can. I think what has to happen though is in addition to an overall commitment from the provider, payer community and government to reduce the cost of health care in the state. There also has to be some consistency

in payment and some reliability in payment, so you can plan over years and get to that trajectory in terms of reduced cost. And you know, the reimbursement has not caught up with the rhetoric. Everyone who is a provider at this table is largely paid on a fee for service basis. They may be at risk in some parts of their contracts, but the coin of the realm is still the fee for service payment. So you know, it's a very interesting theoretical construct to say could we live with GSP or GSP minus a percent.

BAILIT: Right.

WALSH: Yes, if we're paid fairly, we're paid consistently and we can plan.

BAILIT: OK. Diane, what are your thoughts?

ANDERSON: I absolutely agree with Kate. I think that first of all, there needs to be more of a level playing field. We have to be paid adequately for the services that we're providing at the same quality as some of our colleagues down the road, and that is a major issue right now. I think that structurally, if that isn't addressed and is not fixed, then we would be really in jeopardy of being able to

put in the kind of infrastructure that I described so that we can effectively manage patients, coordinate patients better, decrease the utilization and continue to work really closely with our physicians to really maintain patients out of the hospital as much as possible.

BAILIT: Eric, what's your perspective? As a private insurer, what's your perspective of the state thinking about doing this? And I know that United is also in Rhode Island, where they are contemplating the same thing, although they're even more aggressive and they're talking about CPI rather than gross state product. What's your perspective on states taking action like this?

SWAIN: Well, I think it's good if it's in the context of an overall plan. I think it's difficult to put the burden on the health plan to say you need to have the price set at here, unless everyone else in the industry is following suit. And you know, with the providers included and the consumers. I think the other frustration we see out there is we carriers are building innovation that are driving some better outcomes, driving the lower cost, like some of the things we've talked about today, but then I think the challenge is that government sometimes says we want the

cost to be lowered on all your plans across the board. So even those people that aren't selecting the plans that are driving those better outcomes, driving the better innovations, they're getting the benefit of that, and I think that's backwards. I think we need to find a way to drive employers, insurers, everybody, to be making better decisions, buying better products, include the consumer and the employer in that decision making process. So they don't get the benefit of these lower rates if they don't buy the plans that are driving these better outcomes.

BAILIT: Rick, what do you think?

WEISBLATT: I think that we need a target, so I would agree with setting some kind of target for the system. I would agree with Eric that it would obviously make us uncomfortable for the only remedy, all due respect to Jon, being rate denials that are based on sound, actuarial principles. And we also shouldn't avoid, sort of the facts that are in front of us, which have come out twice now from the Attorney General's Office. One, that being at risk doesn't mean lower TME, risk adjusted. It's just a fact, you look at the groups, they're the ones that have been at risk for many years. Those cap deals get readjusted over

time to predictably yield surpluses. So there's not a direct correlation between risk and lower TME.

Another fact as we know and you're hearing from some of the other providers, that there are systems, hospitals, with considerable market power, that are just simply paid higher, so their TME and risk budget is higher. So there are things we need to do, to make sure that we're managing to the target together, and that both if it's providers and health plans job to hit that target, that we're both held accountable for meeting those goals.

BAILIT: Is it good for Massachusetts if ultimately we've got, say seven systems, and everybody's got a target and some of them have a target up here and some of them have a target here, because -- and it was fee for service, they were up here and they were here? Is that a problem and if it's a problem, what should be done about it? And if it's not a problem then obviously nothing should be done about it.

WEISBLATT: Right. So, it's certainly a problem. You want to certainly look at the illness burden of different hospitals and systems, they do vary across hospitals and physician entities. I don't know that we need everybody to be at exactly the same, but the disparity now is hard to

justify. I think the question is how do you lower that gap without the Commonwealth getting back into setting provider rates. I think this kind of conversation, some of the conversation going on at the state level, is a way to look for those solutions. So if you have these large systems, then both the major health plan payers and each provider entity needs to hit those targets, and there needs to be remedies that affect the health plan and there needs to be remedies that affect the provider. You know, some of those targets over time, may need to be tougher for those higher paid providers. I just don't think you can go in and not give enough time to bring these things more in line. So I think we need a plan over a number of years, but I think those disparities need to come down.

BAILIT: Gary, what do you think?

GOTTLIEB: I think first, the target needs to be around total medical expense, not individual transactional prices. As we're describing, the more creativity and innovation will come from using all the resources in the system to best provide care for populations and for episodes of care, and to import the best knowledge to be able to do that, to use market based solutions as much as possible. I do think

that having it objective is a good objective. To Rick's point, I do think that one needs a glide path to that objective, as opposed to a cliff, because the ramifications for essentially providing great care, as well as for the economy, will be pretty remarkable.

I worry a little bit about a hard and fast, potential GSP rule, GSP -- or potential GSP, have never been used for a target in any industry in the country, and so like the SGR, the unintended consequences may be those that we can't appreciate. And so first, I think using an entity like DCFAP or some other, to have a total medical expense truth, to look across all payers, to be able to have a truth that both the payers and the providers understand and can see clearly across payers, so we're not worried as much about cross-subsidization, a variety of other things, and all services, allow us to then be able to point to something that aren't just retrospective claims data and that have that as a major point, and then the target could be set off that.

One of the challenges with potential GSP with a rolling three-year average, is the massive effect that the health care economy has on the overall labor economy, as well as on the general economy. One of the challenges is that there is a latency for being able to control some of

those costs. You have multiyear contracts in terms of labor and resettling of labor costs are both -- as these guys will point out -- local and national issues, particularly in terms of physicians, but for other health care providers and also the other inputs, are national and global issues. That is pharmacy, implants, and a variety of other components, that don't have local markets associated for them, so if you're using a GSP paradigm, you have to figure out how you do that and not destroy what you have in place.

BAILIT: So I'm hearing both that targets are a reasonable idea, but there are problems with targets. So is the issue that we need better targets?

GOTTLIEB: I think that we need to have targets and I think that we can develop them. I think the notion of creating them as hard and fast rules, as opposed to trying them out, trying the data on, and to some extent, as Jon was suggesting, try to figure out how we get to them, much is kind of the -- I think put on the table, it is probably safer than saying, like we did in 1997, here's a target for physician rates and now we have to figure out how to spend

$360 billion, to how to correct them, which is what we're doing in Medicare.

The other problem with isolating the GSP component, which has largely been focused again, on commercial rates, is that we're sitting in the context of substantial expectations of federal reductions. With all of this conversation and with Mark's question of uncertainty, the federal uncertainty, even beyond the ACA, goes beyond sequestration, to issues of both Medicare and Medicaid, as well as the NIH, and a real, absolute constriction in the context of trillions of dollars of debt, of what will happen with that, that's seen as an entitlement, having a massive effect locally, in the state.

BAILIT: All right. I'd like you to comment on one other thing. When Rick was talking, he suggested that one way to deal with the underlying disparity of fee for service rates, which in Harvard Pilgrim's testimony, they reported that it's sort of being echoed in the global payment rates, is to vary the target, so it's not a standard GSP for everybody but it might be lower for those with higher rates and higher for those with lower rates. What are your thoughts about that?

GOTTLIEB: I don't think it's a question I can answer right off the top of my head, to be able to understand one, as Rick was describing, that there are population illness burden differences. I don't understand them that well. I understand them from my own microscopic perspective and what I've tried to negotiate for our system. I don't understand them quite as well, to be able to be empathic to what Mark is negotiating for or what Diane or Kate are negotiating for in that regard. If the issue is one of GSP, it's really related to growth overall in the marketplace, because one is hoping that the GSP is growing over a piece of time, over a period of time. So I would need to integrate a number of questions to be able to answer that one a little bit better, particularly under oath.

BAILIT: OK. Diane, what do you think? Just to repeat, Rick suggested that one of the ways to deal with underlying disparities in prices being paid on a risk adjusted basis, would be to vary the targets that are being set, so that they might be higher for those with lower rates and risk adjusted, and lower for those with higher rates.

ANDERSON: Well, I think in general, due to the situation that we have with the incredible rate inequities, I think that it can't be one rule. I think that there really needs to be something -- whether that's the exact right approach or not, I don't know, but I think that we need to have some different rules for different players if those rate inequities are continuing.

BAILIT: All right. I'd like to give an opportunity for some of the audience questions to be shared with all of you. Do you guys want to read them, do you want me to read them?

WU: Sure. So, we have from the audience, a good deal of today's discussion has been about risk and global payments. Yesterday, the panel recognizes that the PPO market is growing. If that is the case, why are we focusing so much on global payments and what will the market do to reconcile this? So maybe we can start with Jeanne from the employer account perspective.

WYAND: And Christine, which market was growing, the PPO?

WU: One could say that employers are voting with their feet and that there is a switch and an increase to PPO membership.

How does that reconcile or what will the market do to reconcile this with the movement to global payments?

WYAND: It responds a little bit to Áron's earlier question. I think the large employer population is going to be a little bit schizophrenic. And I think you could actually have a global cap type arrangement in a PPO type market. They are not -- I don't believe they're mutually exclusive. It's going to be a problem for employers to reconcile those two components in the environment that they're in today, but I think they can continue.

WU: Reaching back to -- you see the connection to Áron's question earlier. So there are self-insured accounts today who have employees who are part of risk contracts. So setting aside sort of the challenges with respect to episode payments that you described earlier, for where the market is at today, with self-insured employees already in risk contracts, how are the accounts reacting to that?

ANDERSON: The ones that see their increases moderated, they're actually very -- they're happy to see them. It's the ones where they haven't seen the full outcome of some of those

risk contracts, that it becomes a little bit more problematic.

BAILIT: I want to add here, Massachusetts is a little different than other states in that first of all, we have an HMO market that is much larger than what you see in other states. HMO products almost don't exist in a lot of other states. And so because of that, where there are global payment arrangements in other states, they typically start with PPOs, because that's the only commercial product that's around. We've had our global payment arrangements develop in Massachusetts through HMO products, but that's not the experience in other states.

BOROS: I just wanted to ask one other question and I think we're probably running out of time. Mark mentioned complex -- well first he mentioned change as being difficult for individuals. And then later, I came back and talked a little bit about complexity. So I guess my question is, how much do patients need to understand about all of the change we're discussing? Should this be completely transparent to patients, where they continue to go to their primary care physician and get referrals and seek care where they want to seek care, or is this something where

we're really going to require of patients, a new level of engagement, require of employees a new level of engagement, and require of people who are seeking care? And I'll leave aside my personal opinions about which of those is a good idea.

BAILIT: Who would you like to have answer that question Áron?

BOROS: I would be interested in hearing that from the plans, because they sit maybe squarely in the middle, between the providers who actually see the patients and the employers who employ the patients, employees. Let's start there, and then I'd be interested in reaction from the people who are more directly dealing with them.

GOTTLIEB: So I would say yes, absolutely the employees have to be more engaged, but they have to be engaged in a way that they can understand and it's part of their normal life. Some of the feedback we've gotten, even from some of the tiered products, is that people have a hard time understand how we made the decisions. You heard Mark talking about, you can be seeing a tier one physician who is referred to a tier two. Now these are things that people understand in other parts of the economy, but they struggle with some of

the tiered products because they are used to a much more simple, straightforward HMO.

I would say we also need to engage them more in their own health. I mean this is a country that's increasingly unhealthy, and so if we're talking about the kinds of trends we're talking about, given what's coming down the road in terms of morbidity of the population, we're going to crash up just in terms of the health status of the population. So in products, in developing a culture of health at the employer level, all of that, I think we need to do to engage the consumer much more.

BOROS: So I'd like to hear from Mark and from Jon, is that reasonable? Is it reasonable to ask patients to be more engaged in this massively complex world that you know, all of us who eat and breathe this stuff have a hard time keeping up with?

WALDMAN: Well, I mean also to your first question, I think most of what we're discussing here, and sort of the gist of your question, the kind of changes that are being talked about here, that people are really going to engage that change or have to deal with that change at the time they select a health plan. We've always found, even with the tiered

networks, once they're in, once they're in getting care, to my knowledge it's invisible. We don't hear about people saying, you know I went into the Brigham for my baby and you know, I was bounced around to this. It's why are you making me pay a higher co-pay, because I want to have my baby at the Brigham. And then you know, so we explain that.

So I think if you're dealing -- you know, I think your question had two distinct points. To the best of my knowledge, and they all have my direct email and they all have my direct extension because I'm a public sector employee, I never get calls about once in the system, I was treated terribly. It is that upfront, where we're introducing them to a potential change, and they're going to have to make some kind of decisions. I do think it's fair. I think my job is to -- when we went into negotiations, our bottom line was, the status quo was unacceptable. When we had to change to higher co-pays and tiered, we just drew a line in the sand and sold that to them, that status quo was absolutely unacceptable.

So then, with that line in the sand, then it became, and what we're introducing you to isn't necessarily bad; here are the good points. But yes, not you are going to be much more engaged in all the decisions. And that was

doable, and I think even under the new stuff, again, once they get into the system, my sense is this will not impact them as directly.

HURST: I think Commissioner, it's a process. It's a lot of educating and it's particularly a problem for small businesses that have no HR departments. It's all -- the small businesses leave all of that to the insurer, who may or may not be a real credible source for the employee, on what to do. That's part of what we're trying to engage through the cooperative concept. I think you've got to really educate and also, probably more importantly, you need to create real financial incentives to get healthier and to be a better consumer. To some extent, I think we've perhaps have gone a little bit over socialized through community rating by not creating those financial incentives for folks to take charge of their own decisions, of their own wellness efforts and their own purchasing habits. We're going to try to change that through our cooperative and if you get better educated consumers and you get them to be better consumers and purchasers of health care services, and you get them to be healthier, they should be financially rewarded for that. Right now, they essentially are not, through their next year's premiums, and that I

think is a basic change that we all have to start looking at.

BAILIT: Any other questions from the audience?

WYAND: Michael, can I just comment on that one, just from the large employer?

BAILIT: Yeah, go ahead Jeanne.

WYAND: There is a notion, I think the average user of health care would be very confused with what happened at today's panel discussion. Global payments, episodes of care, how things are all structured, really don't fit into the lexicon of the average worker who is trying to put food on the table. At the same time, employers realize that there is a responsibility from their employee population, to start taking some ownership of their own health, and so some of the dynamic is shifting, especially at the large employer side, that it is no longer an entitlement benefit for you to get health care. You have to agree to certain requirements. Whether that's filling out a health risk assessment, it is doing biometric screenings, it's adapting to your disease management -- your disease manager, to

better manage your illness, to keep your BMI down. I mean there are a variety of different rules that are starting to be put on some of the large employer plans, to ultimately have an individual take a greater responsibility of their own health care, because their attitude is once they're in the system, they'll get taken care of, and what employers are trying to do is to keep them out of the health care system.

SWAIN: Michael, if I could, I would like to echo those comments. I mean how can we not include the member in the whole transaction? As I mentioned in my opening comments, you have 100,000 more diabetics than we had in 2001. How can we not include them as part of the solution to the problem? So I totally agree with Jeanne.

MICHAEL: OK, thank you.

BOROS: So, thank you very much. I know we've run a little bit over on time, so I want to thank Michael Bailit for his services in facilitating this panel. Most importantly, I'd like to thank the folks who participated. I know you are all very busy, and I really appreciate you taking the time to engage in this interesting conversation that informs

really pertinent topics and helps me do my job. So, I certainly appreciate that and on behalf of Karen and I, thank you.

Keynote Address on Integration of Behavioral Health

BOROS: In that role he oversees behavioral health services for 1.3 million MassHealth members and manages contracts with managed care entities, and he assisted with MassHealth policy and program design for duly eligible -- for the duly eligible program. Prior to his work at MassHealth, he worked for over ten years assisting hospitals, mental health providers, managed care companies and private consulting firms, in operating and managing behavioral health programs. We've asked Chris to speak today, to the challenge of integrating primary care and behavioral health, because especially for the MassHealth program, but more broadly for the general population, that specific kind of integration is really a key, not only to realizing the promise of parity and equity between mental health treatment and medical treatment, but also the key to managing the whole person when you are trying to integrate care and improve quality outcomes for all individuals. So, I'd like you to join me in welcoming Chris Counihan.

COUNIHAN: Thank you very much Áron and good afternoon everybody, thank you for coming today. I caught a little bit of the earlier discussion on the financing, and hopefully we can focus on -- get to that a little bit in the discussion today, because in this climate, we're really trying to look at both the quality of care, integration of care, how it connects with the overall costs.

I'm going to go through some slides here, but since it's a small audience and I'm certainly open to taking questions from the audience, you can write them down and bring them to the front, or you can just raise your hand. I do have a couple of kind of rhetorical questions in the middle that I want to raise for folks. So before I start, just so I know who the audience is, how many folks represent providers organizations, raise your hands. And how many of those of you are behavioral health providers? Any behavioral health? OK. And how many of you are insurers? And how many of you are Medicaid insurers? OK. And how many of you are policymakers or advocates? OK, great.

So as Áron mentioned, MassHealth, just for a quick overview, has 1.3 million members and most of the members are enrolled with some type of managed care. The program

that I'm going to be showing you data from is one of the plans, which is the PCC plan, contracted directly by MassHealth, with the medical providers, and for the behavioral health services, we have a separate company that currently manages the behavioral health benefit. It's a "carve out." We are now in the process, we had an open procurement, I'll share with you some of the information we looked at to develop our RFR, but our goal in the new contract which we're currently negotiating and hope to have operational in the fall, is trying to develop and improve the integration of care. And so that's why it's helpful to share some of our development with you and get some of your thoughts on how we could be successful in doing that.

Other MassHealth members are enrolled in managed care organizations, there are five of them in the Commonwealth. The bulk of the rest of the members are duly eligible, who have Medicare and Medicaid, and as some of you, most of you probably know, we are in the process of developing an RFR in partnership with CMS, to establish integrated care organizations to develop programs for the duly eligible. And again, the highlight of that narrative will be on integrating behavioral health and primary care.

This is again, this is -- currently, there are about 400,000 MassHealth members enrolled in the PCC plan, and as

I mentioned before, the Mass Health contracts directly with primary care clinicians who oversee the primary care and specialty medical care for the members. And for those members who need behavioral health services, their services are managed by the Mass Behavioral Health Partnership.

I wanted to give you just a quick clinical profile of the members and the services they get. About 121,000 of our 426,000 members actually get care, and for those of you in the insurance field, we call that a penetration rate, and it comes out to about 28 percent. Now in the commercial field it's much than that. Our NCOs are somewhere between what the commercials do, closer to what is currently in this contract. And if you look at the numbers, you'll see about 109,000 are in outpatient services; outpatient medication, individual therapy, family therapy. Almost 10,000 members were admitted to detoxification services for substance abuse addiction, and then about 4,000 members access diversionary services, and this is a unique feature. The diversionary services are something that MassHealth pioneered many years ago, to provide alternatives to 24-hour hospitalization. Under the standard Medicaid benefit, there's inpatient and outpatient and day treatment, but under our waiver, we were able to develop alternatives, including crisis stabilization

programs, which are 24-hour programs, not in hospitals, but with around the clock support from members. And also, community based acute treatment programs or CBATs, which are alternatives to children's inpatient programs. So these programs have developed over the course of the years and then about 9,000 members went into outpatient.

If you look on the pie chart, you can see the clinical distribution of our members. And again, MassHealth members include folks, families and children, and it also includes people who are disabled. So you can see the percentage of folks with mood disorders, which includes depression and bipolar disorder, as well as schizophrenia, and then the other diagnoses that come through there.

So, when we were looking at the development of this RFR, which started almost two years ago actually, and the RFR was released, and we wanted to integrate care, we looked at the expenses of MassHealth to see what was the service utilization of our members; how did it break down in terms of the number of members and the health care dollars that they used. And in order to develop an integrated program, even though this contract is a "carve out," there are activities in which they support the primary care clinicians; giving them information on their medical screening and things like that. But for many years

in the health care field, it was acknowledged that a small number of people used a lot of services, and so we wanted to see what was the breakdown of the population and what were the amount of services that they used.

So this table here is one of what we call at MassHealth, our nine sale document, and it shows you, if you look at the -- the axis on the left is the medical spending; low medium and high, and the horizontal access is low, medium and high behavioral health. And you can see, by looking at the percentages, that the quadrants of the -- the high right quadrant is where the average cost per year is over $60,000 per member, and that is with only 2 percent of the members, they're spending 3.6 percent of MassHealth dollars. And then if you go to the high medical and medium behavioral and the high behavioral and medium medical, you can say there's an additional 13 percent of spending for -- 14 percent of spending involving less than 2 percent of the members. And then if you include the middle cell, with the medium medical and medium behavioral, you add an additional 10 percent of spending for the 3 percent of the members.

So what does this all mean? This population spends about $2 billion in overall health care spending, so 25 percent of the members account for $1.6 billion or 80 percent of the spend, and the top 8 percent make up half

the spend. So when we look at this document, we developed all the clinical data using the DXCG diagnostic categories, not just for behavioral health spending but for all medical spending, and we put that in our data book as part of our RFR and we asked the bidders to say, how would you manage this population? What can you do to reduce the health care utilization, to improve the clinical pathways for these members? And this was one of our foundational documents to achieve that.

So, some of the questions that we asked at the outset, in terms of policy development related to integration of care, management of costs, reorganization of this contract from a "behavioral health carve out contract," to an integrated care contract, was what is this concentration of costs? How does it affect our efforts? The concentration of members, how does that affect our efforts to control costs? Can we control costs? What programs should we designing to improve the outcomes for those members, and how can we ensure that the members get the right care that they need but not be denied care, in order to -- so the vendor doesn't have an incentive to reduce costs.

And then, we know that many of the MassHealth members have other bio psychosocial demographic issues; language, culture, poverty, victims of domestic violence. Some of

our members in this population are involved with the Department of Children and Families and Department of Youth Services, so how can we make sure that the program is not a straight disease management program, in order to meet the special needs of our population. The conclusion that we reached was that we wanted to improve and enhance the integration of care for our members in the PCC plan as a strategy to better match services to needs and also to build stronger partnerships between MassHealth and providers and between our contracted vendor with the providers.

So, the proposal that we submitted, that we distributed last May actually, asked members to look at this population. Again, we had clinical data, using the DXCG framework for different medical conditions, aggregated care conditions, relative risk scores, and we asked them to present to us, a model for a care management program. And as you can see, the concentration of both behavioral health and medical, are intermingled in each of the cells. So we wanted them to tell us how they would improve the care of the members that they would reach out to in their care management program. We also asked, in that design -- many commercial models of disease management pay the insurer a percentage, a small fee, for all the members, and with

that, the insurers do disease management, they send out health newsletters and things like that. What we said in our model was we would only pay for members that were actually engaged in the care management program. That was in our proposal. So we asked the bidders to tell us what illnesses or what disease categories or what combination of categories would they propose to reach out to, based on their own strengths of their own care management program model. So those are some of the questions that we asked.

Currently, there are a number of activities. How is MassHealth integrating care currently? We have a number of initiatives that are promoting integration. One of the major efforts that occurred as a result of the Rosie D. lawsuit several years ago, was behavioral health screening that occurs in all pediatric offices for children under 21. We've achieve up over 70 percent behavioral health screening. It's higher among younger populations and it occurs for all MassHealth members. How many people here have heard of the MCPAP program? Not too many, OK. Well, the MCPAP program is a program where our current vendor, MBHP, has contracts with six regional providers, who provide telephonic consultation to pediatricians around issues of psychiatric presentations amongst their kids. Over 1,400 PCCs access this service every month and they

get help from psychiatrists around questions of assessing medical behavioral health issues and medication issues.

All new members who come into MassHealth receive a health needs assessment, which includes medical and behavioral health assessment, so that the MCO can determine at the outset, if there are any particular needs. All of the MCOs currently have a care management program similar to what I mentioned before, and as part of their implementation and management of members, some of the programs have developed what they call social care management programs. So that if someone in their -- one of their members is homeless or if they don't speak the language or if they're having access -- trouble accessing other supports in their community, the MCO -- it's not a nurse, it's a health navigator or a peer or a community health specialist, who actually helps the member link up to their services.

As many of you know, the Secretary has initiated a patient-centered medical home initiative. There are 46 patient-centered medical homes who are receiving special training to integrate all of the care of members. There's a particular behavioral health workgroup which helps to integrate patients that are in medical homes, with behavioral health care providers. And as I mentioned

earlier, the Duals Demonstration project, which is in process right now, has a primary focus on integrated care between the primary care clinician and the behavioral health provider. And this is a big challenge because many of the Duals, most of the Duals are disabled. They have many -- some of them have very significant disabilities. Some of them are in the upper quadrants of that nine cell that I showed you before. So currently, these are existing efforts in integration that MassHealth is engaged in currently, to integrate primary care and behavioral health care.

So I wanted to give one example of an effort to integrate care, which is the CSPECH model. Has anybody heard of the CSPECH model? Anybody here work with the homeless? Well, the CSPECH model stands for the Community Support Program for Members who Experience Chronic Homelessness. What this program involves is in the homeless community there's a policy that if you find a homeless person housing, then they are much better able to meet their medical and behavioral health care needs. So under this program, the community support team helps the member access housing, through the different housing networks in the communities around Massachusetts, and once stable in housing, the member is much more amenable to

pursue their medical care and their behavioral health care. And in fact, the members who have participated in this program have had significantly reduced medical costs in subsequent years, after they get into the -- find permanent housing. The CSPECH program also involves coordination with the community support programs and the Department of Mental Health, for members who are involved in their services.

So as I mentioned before, the contract -- MassHealth is currently in negotiations with the contractor for the new primary care. We're calling it the Integrated Primary Care and Behavioral Health Contract, for the PCC plan members. The care management program that I mentioned before, to address the high users in the higher cells of the nine cell diagram, were hoping that they will focus on the 5 to 10 percent of the members who use up to 50 percent of the spending. Part of the requirement to integrate the care is that the vendor use a predictive modeling tool to identify members where they can have actionable impacts on their care. And we know that integration of care for this population is important, because if you look at our data -- and I know this has been documented in other places and I think it was mentioned this morning, that someone who has a medical condition and a behavioral health condition, uses

up to two or three times more than if they just have the medical condition alone. So it's very important, particularly for our members, that we identify, that we engage members, and we address both the medical and the behavioral health care needs.

So there are two features of this care management program that are different from other disease management or care management programs. First, as I mentioned before, the vendor will only get paid when they engage the member and maintain them in their care management program. They need to essentially shake their hand, develop and individual treatment plan with them, and maintain regular contact with them every month, in order to receive a reimbursement. The second incentive, the second way that they get paid, is they've proposed incentives for actual health outcome improvements for the members who participate in the program, and if they achieve the outcomes for their members, then they will receive additional payments as part of the -- under the contract. We provided a host of recommended improvements, such as reduced emergency room use, reduced poly psychopharmacology, improvement in level of functioning scores, and the bidder addressed some of those and they also proposed several of their own. So I

think this is another creative way to integrate care for MassHealth members going forward.

Another component of this contract, as I mentioned before, while the main function of the contract is to manage the behavioral health services, another component of the contract establishes a regional network presence to work with the primary care clinicians, by providing them data on their own population of PCC plan members that they see around primary care screening, use of emergency room, different -- distribution of illnesses amongst their folks and some of the prescribing patterns. So in our new contract, we've increased, we've added another section on integration, requiring them to document and measure and improve the integration between primary care physicians, clinicians, and the behavioral health providers. So that's how are they going to identify and refer people within their practices and how are they going to work with the behavioral health providers, other behavioral health providers in their community.

So we're also asking that the vendor coordinate between the behavioral health network management folks and the PCC plan network management people in their office, to continue to improve care. And there will also be a training, and it also is a pay for performance goal for

folks, so that if they achieve HEDIS outcomes and also improve the use of primary care by DMH clients, that's another way for them to achieve incentives.

At MassHealth, there is a recognition. There's a commitment, there's a recognition that providing health care is not just a client coming in to the doctor. There's a lot of value in providing other kinds of support to members, so that they can address their housing issues, their cultural and linguistic barriers within their communities, issues that resulted in their disability, and other communities -- linking them to other community supports. We've made a lot of progress in our CBHI initiative by establishing family partners who are parents with lived experience with a child with severe emotional disorders. Those family partners work side-by-side with clinicians, to help families deal with the problems of their children, help the families access proper school services, as well as medical services. In the adult sphere, there are certified peer support programs, operated by the Department of Mental Health, that have also been found valuable to help adults with severe emotional disturbances, severe and persistent mental illness, access not just mental health services, but housing services and medical services. And so MassHealth is continuing to

expand that to other spheres as we integrate care. There is common understanding now, that in the field of emergency rooms, to help clients navigate through the health care system, peer navigators, community health specialists, those are some of the terms that we're trying to incorporate into this program model as we go forward.

Another obstacle we face in integrating care. Is anyone here from a community health center or a community mental health center? You raised your hand, you're from?

MALE SPEAKER: (inaudible).

COUNIHAN: OK. So one of the goals of integrating care -- and our Medicaid Director, Dr. Julian Harris, worked at a health center, and he said it was really easy if he had a problem, because he could walk down the hall and his client could see a social worker. But if you're in a community mental health center and you had a primary care doc who is available, it wouldn't be so easy to walk down the hall and have the primary care clinician see your clients, because community health centers and community mental health centers have different sets of regulations. So, MassHealth, through Dr. Harris, through Áron Boros, Commissioner Boros, and through the Secretary, are working

with the Department of Public Health, to try to reduce some of those regulatory obstacles, so that there can be greater communication within a facility, between primary care clinicians and behavioral health folks.

There's one particular facility in Southeastern Mass that has two separate entrances; that's how they developed their regulatory -- got around the regulatory requirements. But in fact what happens inside the facility is what I think we all would like to see, where clinicians from the primary care and behavioral health care side can meet each other in the hallway, and they can ask questions on the fly, about medications, about common clients, about symptoms that they don't understand, and that kind of informal contact is what really helps to improve the care for members, when the client is getting served by their primary care clinician or their behavioral health care clinician. Those are some of the obstacles we're trying to reduce, with our colleagues at the Department of Public Health.

The other issue about integrating care is we want to show, what's the outcome of this, what it's going to improve. What's the definition of a positive outcome? And this is a discussion that we, as I mentioned before, in the care management program, were really paying the contractor

to improve outcomes for members. So they're going to have to measure that. We want to try to establish some metrics on defining what integration is, measuring it and improving it, and showing what the outcome is. We expect that in our care management program for example, there are many people with high use of medical care, who may have unmet behavioral health care needs. So we expect that as a result of the care management program, we may have an increase in behavioral health care use, but a reduction, an accompanying reduction in medical care. But these are measures that we need to develop with our contractors, with the MCOs, to determine their effectiveness. Another effort that we're working on, while we do screening for children, for behavioral health care needs, there are some pilot projects to screen for mental illness and substance abuse among adults, but those are only pilot projects, so we're exploring the ways in which we can improve that as we go forward.

MassHealth, along with the other health care providers, is involved in major efforts to keep up with and take some leadership in innovations in health care delivery. What we have here is the slide relating to payment methodology on the left-hand axis, and integration on the horizontal axis. And currently, you can see the

marketplace, where we are today, in the lower left-hand corner, is mostly fee for service, with limited integration. Currently, we have the asthma pilot project which involves bundled payments and some integration. The patient-centered medical homes, which has some bundled payments and some integration, and we're beginning to move that -- as I said before, that's continuing to evolve. As some of you may have seen, the CMS and MassHealth announced the DSTI grants to seven hospitals in Massachusetts. A major part of that initiative will be to achieve full integration of care. I know one of the hospitals that did that, it was in the paper. And then the upper right-hand corner is our Duals initiative, and as I mentioned before, the proposal will be coming out very shortly, to achieve true accountable care. And as we develop and roll out the care management program with our new vendor, we hope that we can move that up to the upper right-hand corner as well, to keep pace with and to define primary care integration with behavioral health. These are the key initiatives of MassHealth and Dr. Harris as we go forward, to move towards integrated care.

So, this is where you folks come in. This is not a closed process. We try to get out and speak to stakeholders, managed care organizations, providers,

advocates. There are many, many challenges as we try to implement these plans. We've heard from folks on a number of current legal issues relating to mental health parity. We have some issues around the way we're paying this new contract, that some folks are concerned may be an incentive to reduce costs, because of the risk arrangement. So we continue to look forward to feedback from you folks as we go forward, and also to work with other purchasers, to make sure that we are aligned. One of the problems that we faced is one management care organization can have a great dashboard. They can have really timely information for a primary care doc, but that may be a very small percentage of the provider's practice. Another managed care organization says, well we've got a great dashboard too. So the administrative burden on the physician, to capture and understand the data from each of these payers, can be a little bit overwhelming. Some of the providers have asked us, can you please streamline this and report on standard measures. So that's just one example of the challenges that we're looking for, as well as to identify some of the key elements of integration.

That's why we're looking for help from you folks, to tell us what things that you're interested in, and what are the key measures of integration? How can we tell that it's

really working? What are the key areas where integration is lacking and it could benefit? So, I will stop there and just ask if there's any questions or feedback or comments from what I've said so far.

BOROS: We have a couple of questions that came in from the audience. If we go all the way back to the chart, the 3X3 table identifying the high cost members. In that red cell in the upper right, do you have a sense of whether medical costs or behavioral health costs are driving the spending in that cell?

COUNIHAN: Yes.

BOROS: I'm sure it's an interplay, but where is the bulk of the money being spent?

COUNIHAN: The bulk of the spending is in medical costs. Probably 80 percent is in medical costs. And again, each member has their own cost, but it's probably three or four to one medical to behavioral health care costs in that cell.

BOROS: So this is focused on cost alone. Have you looked at clinical outcomes at all, for people in different cells, and try to compare them, mortality for instance.

COUNIHAN: That's another good question Áron. We do know that for folks with severe and persistent mental illness, their life expectancy is about ten years less than people who don't have severe and persistent mental illness. So one of our pay for performance incentives in the new contract, is to improve the linkage with primary care for DMH clients, to try to address that issue. So I think -- and the question about morbidity and outcome for folks with different disease categories is that you know, the people in each of these cells have different combinations of disease conditions, and at MassHealth, we don't have the expertise to really do the drilldown, to see what conditions could be beneficial or where is the life expectancy. So we are hoping that our vendor can use their predictive modeling to say well here's where we can have an actionable outcome or here's a clinical pathway where this combination of treatments or illnesses, could lend itself to some improved health outcomes.

BOROS: I have another question about your outreach to primary care physicians. What's the feedback been from providers, about how primary care physicians interact with the behavioral health system and providing behavioral health care to their patients?

COUNIHAN: Very good question. I think there is -- the primary care clinicians usually say, either I have somebody that I always refer to, or if I try to refer to behavioral health care, there's a waiting list and there's no services. So clearly, we want to improve the working relationship. As many people know, a lot of behavioral health care is provided in a primary care office, so we want to strengthen the ability of primary care clinicians to provide behavioral health care, either by having a clinician in their office, a behavioral health care clinician, or supporting the primary care clinician who is providing medication services. Again, there are some regulatory obstacles to having a clinician in that office. There's a lot of primary care clinicians value consultation, but if you have a behavioral health care clinician, there's no way to reimburse for that consultation. So those are some of the ways we're trying to do that, and we really want to try to improve that.

Part of the question is what does a primary care clinician really need, how can we work with them? And a small office may not have an administrative assistant or a nurse or a nurse practitioner who can be more on the line. But we also know the value of sharing information, and I think that's the challenge, is how do you make information that's actionable and usable by a primary care clinician, so that when they see the patient, they're able to intervene correctly.

BOROS: Do you either have targets for cost savings that you're trying to achieve by looking at some of this integration, or have you measured any cost savings in pilot studies?

COUNIHAN: In the RFR, we intentionally did not put cost savings as a goal. We wanted to improve the matching of services to needs. We wanted to improve the clinical course of treatment that these folks had. And again, the combination of aggregated care conditions and multiple chronic illnesses, indicates that there can be improvement in care. So we're not expecting -- we expect, as Don Berwick says, by managing care better, we expect to achieve cost savings, but we don't have any specific targets. Have there been

other examples of cost savings? We do know, as I mentioned in the CSPECH program for the homeless, that there was a reduction of about 40 percent in overall medical costs for folks who participated in that, and there had been other reductions in the use of alternatives to inpatient services. We do know that in our Children's Behavioral Health Initiative, which added five remedy services, that since the onset of CBHI services, we've reduced inpatient by about 20 percent for children and adolescents, so that's some indications. But again, part of our strategy is to kind of plot the baseline and see where we can improve cost savings.

BOROS: So then we received two questions on the CSPECH program that you mentioned again, so if you'd be willing to speak to that. So the first question was you mentioned some of the -- I believe in here you mentioned some of the housing... I mean, obviously, this is a homeless population, so housing becomes really principal to not just their medical care but their overall health. So the question is, is the program integrated with Housing First efforts, to house homeless people, as opposed to shelter based strategies, on the same idea that housing is really a foundation of reducing costs and improving outcomes.

COUNIHAN: Yes. Yes, the whole idea of CSPECH is to support the Housing First philosophy, where if you do -- the philosophy is instead of having you know, you have to get into treatment and then we'll get you into housing, it's the opposite approach, where we're going to put you in housing, regardless of whether you're actively abusing substances or whether you're taking your psychiatric medications or whether you're taking your medication to manage your diabetes. The goal is to get you into housing. So that's what the community support program providers do. They really work with the Housing First folks, with the shelters. The program is in collaboration with the Mass Housing and Shelter Alliance, to find permanent housing for folks, and then work with them to get behavioral health and medical services.

BOROS: And then the last question I have is along the same lines, about when a homeless person is in an emergency department or even in an inpatient facility, one of the real struggles is where they transition to. And if there's no receiving facility, they end up essentially living in an ED or in an inpatient facility for extended periods of time. How do you approach that problem and are you trying

to build capacity on either side of that equation, to help reduce that problem?

COUNIHAN: We do have sometimes, occasionally, there are people who are in emergency rooms, waiting for inpatient treatment. Sometimes they're homeless people, sometimes they're uninsured, sometimes they're commercially insured, sometimes they're insured by Medicaid. So we do work through our emergency service programs, which are across the state. They are expert behavioral health clinicians, they assess the client, they work with the insurer or the hospital to find an appropriate bed. We don't keep people out of the inpatient units just because they're homeless. The issue comes when they are in the inpatient unit and they need to go, a discharge plan needs to be developed, but that's again where the CSPECH program provides additional support to the inpatient, psychiatric inpatient units, to have a better chance of finding permanent housing.

WU: Chris, on a later slide, where you have two vectors; one is care integration and the other vector is payment integration.

COUNIHAN: Yes.

WU: Global payment. You had mentioned earlier, what you called socio cultural considerations in care delivery, and I would imagine as you've described, services are costs to appropriately address linguistic barriers and those other factors in the delivery of care. Are you aware of any initiatives or as along the vertical vector, as global payments are being set for a patient population, funds that are cognizant or allocated to addressing populations that have higher socio cultural sort of risk status?

COUNIHAN: Yes, that's a good point. The asthma pilot, folks saw, one of the benefits of that bundle payment is that the provider can go in and provide a vacuum cleaner to the home where there's mold, so that if you get the mold out of the house or the apartment, you'll reduce the symptoms of the asthma. So that's one way to use the funding. And obviously, people who live in substandard housing where mold is a much greater problem, that's one benefit. As I mentioned, the managed care organizations, part of their contracts involve a care management program, and some of their staff are what they call social care managers. So they can address -- they have people who speak different

languages, they have people who are aware of the different cultural approaches and sensibilities of their different cultural populations towards mental illness or substance abuse, so they're able to address those issues. And I think part of the idea of a global payment is to incent either a provider or a primary care doc or an MCO, to use the funds, not just to provide fee for service medically necessary services, but to really figure out what does the client need to be able to participate in services.

WU: And Chris, if there are differences in the populations that a particular provider is servicing, is caring for, in terms of the index of socio cultural needs, will there be differences in payment that sort of reflect different penetration rates of say, non-English speaking proportion of the population being cared for.

COUNIHAN: That's a good question. I know there's probably people in this room better than I, and Áron probably knows about risk adjustment based on clinical presentation. I think there's a good argument to be made for people who have -- and I don't like the word risk for cultural issues, but there are additional requirements. Obviously, people who are handicapped, people who are blind or hard of

hearing, in addition to people from different cultures. I don't know of any methodology or algorithm to calculate that, so I think that's something that we have to look to, because we do know, and I think this is where, in the behavioral health world, both for the adults, through a certified peer specialist, and for the family partners, that the clients themselves respond to someone who is from their background. And there's a program, not just a family partners, but also I know in the western part of the state, for the Latino populations in one of the cities... I forget. I think it's people who are diabetics, and the clients don't want to talk to a nurse or a doctor, but they'll talk to people from their community and they'll be willing to engage and find out about how to be -- have a much greater chance to comply with the medical regimen that will help them deal with their condition.

How do you calculate the cost of that? That's a good question. Again, we would want to look at the cost and then try to incent for an outcome. And hopefully through this care management program, we'll learn more about the members, and are they from a particular background or are there additional obstacles in their life based on their background or culture. Any other questions from the audience? Yes?

FEMALE SPEAKER: Chris, you said that one of the components you guys were thoughtful in changing, was making sure that a component of payment in the care management prove that the member is actually engaged in care management. Has there been consideration about also ensuring that the actual care provider is engaged in that care management plan?

COUNIHAN: Yes. I won't go into all the details, but there is a requirement for an individualized service plan for the member, and that plan includes the health care that they're getting from their community providers. And so part of the job of the vendor will be to coordinate everybody, to make sure the member is getting services, and with access to real time data to show what they're using. So we definitely want a requirement that all the providers are appropriately involved. Yes?

MALE SPEAKER: I would just like to offer the assistance of the Mass League of Community Health Centers.

COUNIHAN: Yes.

MALE SPEAKER: One of our members of Boston Health Care for the Homeless, with regard to your problem around resolving the issue around patients being stuck in emergency departments. We're involved in a project that's called (inaudible) emergency room services. So if you'd like more information about that project, I'd be glad to provide it.

COUNIHAN: Great, thank you very much. Yes, there are many initiatives, and that's one I knew a little bit about that, that are going on, that we at MassHealth are not always aware of. So it's helpful to hear back from you about projects that you're involved in and to see what the results are, and when there are good results, to make sure we share those results with other folks, and then also, to try to bring the parties together. There is actually going to be -- to promote integration, the League of Community Health Centers and the Association of Behavioral Health, representing the mental health centers, are going to have a summit in July, and they're going to -- to try to address this topic of integration. Well, I want to thank you for your very thoughtful questions and wish you luck with the rest of your conference and thank you for your time.

BOROS: Thank you very much.

Panel Discussion on Provider and Consumer Engagement in the Health Care Market

BOROS: The final panel of the 2012 cost trends hearings, we're going to run this panel -- thank you first of all, for all of our guests joining us. I'm going to let Michael introduce you and allow you to make your opening statements. We're going to run this panel on the same format that we ran this morning's panel, including the three to five minute opening statements, and then a moderated discussion where Michael has prepared some questions, and then the three of us representing the Division of Insurance, the Attorney General's Office and the Division of Health Care Finance and Policy, may have an opportunity to interject additional questions, as well as soliciting questions from the audience on the note cards. So with that, I'll ask Christina Wu to swear you in and then I'll turn it over to Michael Bailit.

WU: Panelists, raise your right hands. Do you swear that the testimony you are about to give in the matter now at the hearing, will be the truth, the whole truth, and nothing but the truth?

PANELISTS: (answer in the affirmative).

WU: Please identify yourself by raising your hand, if your testimony today is limited for any reason, if there are any restrictions placed on the capacity in which you testify here today, or if you have any conflicts of interest that require disclosure.

SMITH: If there's discussion going on at MassHealth, that is are not public yet or you know, an RFR is not live yet, I would not be able to speak in detail to things like that.

WU: OK, thank you, for the record. Anybody else? All right.

BAILIT: Good afternoon panel, audience. We're going to spend this afternoon talking really as a compliment to this morning's discussion about marketplace trends and their impact, but you represent very different organizations and stakeholders in the panel that we had, sitting actually on both sides of this morning, and so we want to solicit your perspectives so that they are heard and understood as well as those of the purchasers, mostly hospital providers and payers, and private payers I should say, that we had

sitting in the panel this morning. I'm going to ask you questions that are organized around some of the theme that I asked the panel early this morning, and ask you to share your perspectives during this afternoon's discussion.

Before we start, I would like to introduce each of you, in alphabetical order. Ellen Bishop is a practicing board certified family nurse practitioner and currently serves as a legislative co-chair of the Massachusetts Coalition of Nurse Practitioners. She is a faculty member of the Commonwealth School of Nursing at Boston College.

Dr. Ron Dunlap is a cardiologist who is practicing at South Shore Hospital and Beth Israel Deaconess. He is the current president elect of the Massachusetts Medical Society and serves as a member of the Massachusetts eHealth Institute and the state's HIE Provider Adoption Group.

James Fuccione is the Director of Legislative and Public Affairs for the Home Care Alliance of Massachusetts. The alliance is an association representing 200 home care providers across the state that are both federally certified to provide services for Medicare and Medicaid beneficiaries, and to private pay home care.

Brian Rosman is the Research Director of Health Care for All, an advocacy organization dedicated to expanding access to quality affordable health care in Massachusetts.

Brian's work focuses on policy research and analysis related to Massachusetts and national health reform, public health coverage programs, health payment methods, private insurance concerns and other policy issues.

Ken Smith is the Director of the Office of Long-Term Services and Supports at Elders Affairs. The office is also part of the Executive Office of Health and Human Services Office of Medicaid. Ken was previously the Assistant Commissioner and Chief of Staff at the Department of Developmental Services, where he headed up the role and settlement agreements, compliance and operations.

So, welcome to all of you. You are invited to share prepared statements and have three to five minutes to do so. We have a smiling, or he will be smiling, now he's smiling, timekeeper here, and he'll give you some indication if you are nearing the end of your five minutes. So why don't we go in alphabetical order and Ellen, that means we'll start with you.

BISHOP: Thank you. My name is Ellen Bishop. I'm a nurse practitioner currently in family practice. I am also the legislative co-chair for the Massachusetts Coalition of Nurse Practitioners. Nurse practitioners have been providing primary care services in the United States for

more than 40 years. The Mass Coalition of Nurse Practitioners has been advocating for nurse practitioner practice for 20 years. We have had many significant advances in legislation supporting NP practice, including prescriptive authority for NPs. In 1992 and in 2008, we received recognition of nurse practitioners as primary care providers. Among the main objectives of the Mass Coalition of Nurse Practitioners is the support of legislation that increases access to high quality health care for all citizens of the Commonwealth. Thank you.

BAILIT: Thank you. Ron?

DUNLAP: I've been a practicing cardiologist for about 30 years. I spent 15 years full-time, teaching at Harvard, in an academic situation and the last 15 years or so, I've worked part-time in academics and my practice on the South Shore. I've been very much involved in the analysis of organizations such as ACOs, and I've been on a board at South Shore Hospital which is dealing with how we will clinically integrate physicians in our region. I've been very much involved in looking at payment reform and getting physicians to begin to adjust to how they will function in the future. But I think there are key issues in terms of

market share and the size of various systems, that are creating some issues for physicians or major issues for physicians, in terms of how they will practice in the future.

BAILIT: Thank you Ron. James?

FUCCIONE: Good afternoon. Thanks for the opportunity to be on the panel. I'm James Fuccione from the Home Care Alliance of Massachusetts and as Michael mentioned, we have 200 home health agency members across the state and about 130 of those are the ones that are federally certified to provide Medicare and Medicaid services. We also have kind of the remainder of that, about 80 agencies are private pay, so individuals or families pay out of pocket for homemaking services or a nurse to come in to assist them. We have created an accreditation program, kind of a seal of approval, for certain private pay agencies that meet certain quality standards and business practices and such. If they meet those standards, they get a seal of approval from us, and it's kind of been a helpful for consumers to use, to find private pay services. All total, all of our agencies provide about 3 to 3.1 million visits to home health patients in the Commonwealth every year, and the

services aren't just for the elderly, although that's a large part of it.

Our members provide services from maternal child health services to hospice and palliative care and everything in between. We provide pediatric home care service, chronic disease management, Alzheimer's dementia care, behavioral health. Our members care for about 14,000 duly eligible individuals, so we're very much involved in that effort that's going on as well. With all that going on, I think our members see a lot of opportunity with moving towards accountable care organizations.

BAILIT: Thank you. Brian.

ROSMAN: I'm Brian Rosman from Health Care for All. Health Care for All goes back a long ways, we go back 28 years. A lot of people are calling this health reform, you know health reform 2.0, but in our mind this is probably the fourth major health reform that we've been around for, and we go back to 1988 and Governor Dukakis. Anyone remember the big reform and the transition of Medicaid into MassHealth in the mid-nineties, and of course can I say Romney Care, am I allowed to say that? Our organization, we've sort of always been on the frontlines, pushing for

greater access to coverage. We have marching, "Cover the uninsured, more coverage for the poor." And now here we are with a new challenge of cost and quality issues and I've got to say, it's a tough transformation for us. It's difficult to go organize people to take a march to say, "Risk adjustment must include non-actuarial factors." It's a harder concept to get around.

But what we did is we formed a coalition around these cost and quality issues, and we call it the Campaign for Better Care. And the reason we called it that, not just a campaign for cheaper care, because if this transformation of this reform does not improve care at the same time as lower costs, we think it will really be a failure. We can lower costs by increasing co-pays, increasing deductibles, we can reduce benefits. Those are easy ways to lower the cost of care. So the challenge is how do we improve care by making it better, by improving the quality, and that's the tough thing. So we've organized a broad coalition, includes groups like AARP, American Cancer, American Heart, a bunch of mental health organizations, groups concerned about people with disabilities, the Greater Boston Interfaith Organization, which Senator Moore bleakly referred to yesterday, and we've come up with sort of ten principles about how to implement payment reform in a way

that improves care and not just leads to lower cost care. So we're excited.

The cognitive dissonance for us is back in the late nineties, we were the leading group fighting against HMO abuses, and we led the battle for a patients bill of rights to say HMOs are too aggressive in restricting care, and we need to do something about it. And now we've come around and said OK, let's see how we can make this ACO idea work, which we really think can be different than the old style HMOs if done right, and I guess the if done right is going to be the hard part for the Legislature to figure out in the next few weeks, and then for all of us to figure out as we implement whatever passes.

BAILIT: Thank you Brian. Ken.

SMITH: Hello. I'm Ken Smith and I'm the Director of the Office of Long-Term Services and Supports. My division of Medicaid and Elder Affairs includes all of the services and supports that are available in the community for elders and individuals with disabilities. My programs run the gamut of the fee for service programs, as well as coordinated care. My Senior Care Options program, SCO, and PACE, Provision of All Inclusive Care to the Elderly, are both

part of my programs. I have background as a licensed nursing administrator, so I ran nursing facilities, part of institutional care, and I've also been a home health administrator, so I've also run home health programs in the community. The programs that are now in my division, I've been out there in the provider community for many years, many years ago, running those programs.

Recently I've been, for the past two years, on the steering committee for the Duals Demonstration grant project, as well I've been on the steering committee of the Money Follows the Person Demonstration grant. The Money Follows the Person will help to de-institutionalize many individuals in the Commonwealth living in nursing facilities or chronic rehab hospitals, or intermediate care facilities for people with intellectual disabilities. So I have many views and thoughts on both how the fee for service meets individuals' needs, but also how successful coordinated care for the elderly, as SCO and PACE programs have been very effective and helpful in meeting all the assessed needs of those populations. So what's most important for my team and the programs and services that we implement and operationalize daily, is that the citizens of the Commonwealth who have MassHealth, have access to community services or institutionalized, they may choose.

That they have choice and that those services are of quality. Thank you.

BAILIT: Thank you Ken. Thank you all of you. I'd like to begin by asking you some questions having to do with the trend within Massachusetts, in both the private commercial marketplace... I shouldn't say both, because I'm going to give three examples. In the private commercial marketplace, the Medicare marketplace, and increasingly in the Medicare marketplace. Did I say that twice. All right. I was up a little too late last night, so it's starting to kick in. Medicare, Medicaid and commercial. There's a trend towards global payment in all three, and so I'm interested in getting your perspective from where you sit on this trend. Ron, I'd like to start with you. You're here with at least a couple of hats, and so I'd like to ask you this question, first with you wearing your South Shore Hospital cardiologist hat, and then I'll ask you from a Mass Medical Society perspective. First, you're a cardiologist at South Shore. My question is, to what extent does your practice and maybe South Shore as a larger entity, feel prepared to deliver care as part of an integrated care system, and what steps are you taking to be more accountable in the future for quality and cost?

DUNLAP: I think the most difficult part of that is the information systems problem. The South Shore has no real dominant player in terms of large city institutions, partners. We have Steward, we have Beth Israel Deaconess, and we have some penetration from Boston Medical Center. So that our group has physicians that are on the staff of every teaching hospital other than Mass General in Boston, because we deliver care for a broad spectrum of people. One of the issues is that by doing that, we have access to the Beth Israel IT system, we can look into Partners and so forth, but there's no integrated way to collect data, for instance from our practice, or from all of the systems, to be able to look at this.

Individually, we've come up with a system called the South Shore Physicians Electronic Network, which is allowing independent physicians to come together on the same electronic medical records, so that we can exchange data, but we will also now develop a common database on patient quality and so forth, so that we can begin to assess how we're managing patients. So before you can take on bundled payments, you really have to look at how you practice now, where your over-utilization is, where the risk are for various different populations, which until

you've looked at this, managing patients with very tight margins such as you have in Medicaid and Medicare, in the future will require data and systems that will allow you to look at where your waste is.

Now the problem is that large systems like Kaiser, Geisinger, they've been doing this for years. There's an excellent system in the Midwest called Advocate, which is something like nine hospitals, it's about 4,000 doctors, 900 of whom are employed, the others are independent practitioners. But they've been doing an accountable care model for 14 years, very successfully, but it took them time to organize. Part of it is unfortunately, even working on these health information exchange committees, where there are some very bright people trying to link systems, the short-term answer is to have everybody on the same system.

So there are two issues. One is that individual practitioners are having trouble paying for information technology. The others are on multiple different systems, so how they're doing this, didn't have a community view. My view would have been to integrate the entire community, across walls of providers, so that we are all electronically connected so that we can pool data. So in order to look at the bundle payment thing, you have to have

that experience, and until you do that -- so we've done an excellent job at South Shore, in risk contracts. We have very high AQC marks and so forth, but this clinical integration is a much larger issue and requires unfortunately, large amounts of capital to get everybody on the same system. So you see partners moving from their current system to EPIC, you know you see Atrius on EPIC. So even though we're trying to integrate things across networks so you could be able to practice in different environments, we haven't reached that yet, so the large providers who are already on a single system are way ahead of the game in terms of analyzing data, way ahead on the ability perhaps, to do the bundled payment initiative. So that's really the handicap of the system.

At our hospital, there's a five doctor board that meets with the administration four hours a week, and we've been trying to work on the clinical integration model for how we might do this on the South Shore. But even at that, we have physicians who work at different hospitals, that are not South Shore oriented. So we need a system that allows us to move across barriers and the technical issues of that alone. The health care bills which say that primary care physicians will be in one system, won't work as well in our area, because we have primary care providers

that provide for many systems. So if you now force people into one system and they can't provide care to the others, the patient access goes down, the ability for providers to move across those walls goes down, so that the intense competition between the large networks, for alignment and dominance, is really shaping what's happening with physicians. At the current time it's less about quality and more about market share, which concerns me.

BAILIT: In addition to the information system and sharing challenges, are there other challenges that face your cardiology group?

DUNLAP: I think one of the major challenges is just looking at ourselves. Because of national certification, we've begun to look at how we utilize services, whether we over-utilize certain services. And so many groups could not answer whether they order too many of one thing or another, but once we get the data, we'll be able to see where the outliers are, and you want to try to pull people toward the center, so that you're not over-utilizing services. Once you can do that, then you're in an excellent position to market your services to networks that need efficient providers.

BAILIT: OK, thanks. So, if you take your South Shore cardiologist hat off and put on your Mass Medical Society hat, this morning our provider representatives were I think exclusively hospital executives. Now they had owned physician practices but they were hospital executives. I'm interested, from a Mass Medical Society Perspective, where the society represents physicians who are employed by big systems, but also physicians who are practicing independently, your perception of their readiness to deliver care in integrated systems where the group practice, the hospital system, whatever the accountable entity is, is essentially being given a budget and being told to manage to a budget with a bunch of quality measures attached to that budget.

DUNLAP: Basically, the society has moved -- because of the change in the paradigm, young people are going to be employed for the most part, I think. Sixty-five to seventy percent of graduates of medical schools in America last year took a salary job. So the society has more or less reached out to larger organizations, to try to get them to join, but in fact the history of it is that more of the activity and the activism in society have been people who

have been in practice, so that we have now enrolled large groups, Mass General and so forth. But to get their physicians active in terms of participating is more of a challenge, and so we're trying to make more of what we do relevant to young physicians. That's a challenge, but I think that what you see is that medical students are quite involved, and then there's about a 15-year hiatus where people don't show up because they're raising their kids and doing other things, and then in their forties or early fifties, they get involved, and some people into retirement are very much involved in activity. So the issue is will the young people working in these large organizations where many of the day-to-day problems that private doctors deal with are taken care of by network administrators, be involved in terms of what happens to them in the future?

The physicians that are already out there, we are around the state, talking about accountable care, explaining, explaining health care reform, trying to get people to pull together, but the bottom line is that bigger is better. Where physicians have pulled together themselves to organize, they're in a much better position to partner with hospitals. Otherwise, I think the situation would be more or less dominated by large hospital systems.

BAILIT: If I were to take the temperature of the medical society membership right now, on global payment, what would I get back?

DUNLAP: I think that people are worried. They understand the concept. They don't believe that they have the data. We have for instance, more input from Atrius, so they've been helpful in some leadership meetings, talking about quality and how they manage things. It's clear that they're well along the way to perhaps being able to do this, so we would like to leverage some of their knowledge in trying to help other groups come together in terms of understanding how to do this.

BAILIT: OK, thanks. James. As your organization looks at global payment, do you view it as an opportunity or as a threat?

FUCCIONE: I think we view it more as an opportunity, just for kind of all the services and competencies that I mention, that agencies have, you know all the things they specialize in. I was talking to an agency recently that said we essentially provide everything that a hospital can provide

in the home, except for surgery and X-rays, you know and that goes for therapy, IV therapy and home chemo for kids with cancer, I mean all the way down the line there are some really innovative things that home care agencies are doing. So I think a lot of agencies, especially the kind of experienced visiting nurse associations that have been around for a hundred years or more, see this as kind of a chance to prove themselves and show what they can do. Plus, in terms of what Ron was saying, I think there's been a little bit of challenge that home care wasn't included in the High Tech Act, to move providers to electronic medical records. So home care wasn't included in that, but I think now we're starting to catch up. I think a majority of our members now have some form of that health IT system. There's also a project going on in Worcester, the IMPACT project, it's an acronym that stands for Improving Post Acute Care Transitions, and it's basically using home care skill nursing facilities, and it's getting kind of a common form that's used as a universal transfer form so that care transitions can be made a little bit smoother. But I think it's more an opportunity for us, more so.

BAILIT: I'd like to follow up and ask how you think that opportunity can be realized. So can you talk about the

relationships your members have with health centers and with other primary care practices, with hospitals, specialist groups, and how does relationships, they need to change or evolve, in order for you to realize the opportunity.

FUCCIONE: Right. Well, the Affordable Care Act has had a lot to do with our getting more involved with the physicians. There's something that came out, a federal health care form called the Physician Face to Face Encounter Requirement, that says for Medicare patients, you have to be certified by a physician to get home care, either 90 days before the start of care, home care, or 30 days after. So that's kind of forced a lot of collaboration where there wasn't any before, with physicians. So there's kind of that part of it, and also some other things that have come out of the Affordable Care Act, you know the grants and demonstrations have kind of helped agencies to work more collaboratively with health centers and physicians. What was the second part, I'm sorry?

BAILIT: I was looking at range of providers. Let me give you a case example. So let's say South Shore has an AQC contract with Blue Cross and your members think you know,

we could help South Shore manage some of its members, to care for some of its members, patients, through the services that we provide. So, I'm interested in, is there a new relationship that needs to be developed between the home care agencies that are in the service area of South Shore, that don't exist today but that would need to exist for there to be a relationship to deliver integrated care to South Shore's patient population for which its responsible?

FUCCIONE: Yeah, I think that -- and although we haven't missed the boat on this completely, kind of the patient-centered medical home movement went on a little bit and left home care behind, even though what we've been trying to promote is that home care agencies can be kind of an extension of the medical home, have that availability of after hours care for the medical home, and just kind of be the eyes and ears of the physician practice in the community, in the home, and really see what's going on with medications in the home; whether they're actually taking their meds as they're supposed to, et cetera. I think if we can get more involved in the medical home effort, then that will extend out, and with everything going on this week and lately, I

think that you know, it's up to us to be more involved and kind of link in with this whole effort.

BAILIT: I'm interested. You may not know the answer, but do you know, does South Shore have a relationship with home care agencies in its service area? South Shore VNA?

DUNLAP: South Shore has its own VNA. It does relate well to other VNA services in the region, but I think that in order to do this, you really almost have to vertically integrate your system so that for instance, you talk about bundle payments or episodes of care. So let's say that you need your knee replaced. You might come to me to be screened for your cardiovascular risk assessment. You might then go to your surgery, have your knee successfully replaced. You would then go to a rehab center and then from there you may have home health care. Now, for a knee, the episode of care may be six months, because that's the time it takes from start to finish, where you recover. That means that every agency along the line is involved in that bundled payment. So if you slip and fall or get RMSA in the nursing home or if your home health care person, occupational therapist or whatever, is not good enough at

showing you how to get out of bed and you fall and you come back to the hospital, the system has failed.

I think Larry Garber is the one who is doing the initiative, trying to link the home health care and the rehab agencies with the hospitals. That was a forgotten part of the Accountable Care Act, and I think that therefore, people who have enough money to -- if you're at Mass General and you have Spaulding, you have a vertically integrated system, you may have more control over the quality and what happens to your patients. To do that otherwise will require us to cooperate on a large scale, to integrate the information transfer and the care standard so that we all -- all of whom will share a part of this payment, will be able to do it successfully, without having the patient --

BAILIT: James, your home care agency members are going to have to develop corporate affiliations with all the big health systems?

FUCCIONE: Well, I think -- well, two thirds of our members aren't aligned with a hospital or a health system, so I think that's part of the concern and the fear from our

membership, is that they're going to be forced to create these partnerships where there are none, so.

BAILIT: Ken. What does an accountable care organization look like for Medicaid beneficiaries who are receiving community based, long-term support services? Is it an expansion of the PACE program, so it's super sized, or is it a new delivery system or a different delivery system model?

SMITH: In a lot of ways, it should be impervious to the MassHealth member if it's done well. Let me just take a second to explain the PACE program, it might be helpful for folks. It's a centered model. The vast majority of MassHealth individuals who go to -- who are part of the PACE program, they go to an adult day health run by the PACE program, and all of the medical needs that they have can be met right there at the center. So their physical therapist is there, their primary care physician, their nurse practitioner, and the PACE program was really -- and this is my PACE director is always stating this to me when they hear about the accountable care organizations. They say we started this. We've been doing this since 1980 nationally and 1990 here in Massachusetts. So in a way Michael, that's exactly what it could look like, that your

care is coordinated in a very efficient manner and typically at a site based. If that's done well, and it is sort of a larger scale version of the PACE program, again it's impervious to the member. They won't notice that their care is being delivered differently.

BAILIT: But if it's site based wouldn't they? I mean, if I'm living in the community and I'm not going to a site during the day and all of a sudden I am told I need to go to a site during the day. Isn't that going to be something I'm going to notice?

SMITH: Right. I was thinking about people that are already in that type of environment you had mentioned, is the growing of the PACE program. But typically, if you are taking various transportation or trying to get rides with a daughter, a daughter in-law, or if you're a MassHealth member and you utilize HST, Health Service Transportation System, you are currently being shuttled to many different places to get your care, throughout the course of the week and the course of the month. So if you shift it more to a center based care, if you're not already involved in that, and many of our MassHealth members in the SCO, in the Senior Care Options, are not at a site based, but when they

do migrate to that, they actually appreciate it and feel as if it's a lot less discombobulated.

I visited some of our MassHealth members who are in a SCO and PACE program, and they will comment on how taxing it is with trying to marshal the transportation or working with family members or a case worker from an aging service access point, to try to get that transportation coordinated, it's one of the most difficult things for that person who is elderly or disabled. And that when it does go to site based care or the senior care options plan, which is not site based, coordinates it for them and coordinates more of a center based care delivery system, it's greatly appreciated.

BAILIT: So, Senior Care Options or SCO, is really a plan based model, where the plan is providing lots of service coordination and care management, whereas an accountable care organization is really provider based, much more like the PACE program. So what are your thoughts regarding all the Medicaid beneficiaries who are receiving community based, long-term support services, who may not want to go to a center based program, and right now they're either being served by a SCO or they're not. What are the new

options or are there new options for them, that are provider based ACOs that are not center based?

SMITH: Right, OK. So one of the options, we'll start with SCO. If you're not in PACE, that's center based, Senior Care Options will coordinate the care for you at your home. So for example -- and I look to Ellen. I was at a Senior Care Options enrollee's home a few months ago and while I was there the nurse practitioner was there with -- she was on her laptop with the care planning system was up, and she was reviewing with the individual, the services that she was getting for the week, what was planned for the month, basically reviewing her care plan with her. And she was doing it in a self-directed manner as possible, without it being called self-directed. And while I was there, the homemaker had come, the home health aid, the Meals on Wheels was delivered, and it was coordinated at the person's home. And this is very specific to someone who is somewhat more homebound, but it really was coordinated care from the SCO plan and from the nurse practitioner model. Two of the four SCOs have a nurse practitioner model that completely coordinated it. And again, to what I was saying earlier, it cuts down on a lot of the transportation issues.

BAILIT: But the SCOs aren't contracting with providers as ACOs.

SMITH: No. No, but they have a provider network. I listed some of the providers that they network with, that are there, but what they do network with is a geriatric services and support coordinator, and this comes from an ASAP. So for those of you who don't know, that's the Aging Service Access Point. Many years ago they were called the Home Cares. So, each person in a SCO has a geriatric services and support coordinator who attends their care plan meeting with them and helps coordinate their care, along with if you have the nurse practitioner model. Am I answering your question?

BAILIT: Not quite. I'll give you a scenario. So I'll say South Shore again. South Shore says you know what? We're doing a really good job of serving commercially insured people under global payment arrangement, and let's just imagine that it's also got a contract to do so for Medicaid beneficiaries who are not receiving long-term care services. But they decide you know what, we're ready to expand. We'd like to serve all MassHealth beneficiaries,

including those receiving long-term services and supports. And so we're partnering with our local ASAP and we want to contract on a global payment basis with MassHealth. How do we do so? So that would be an ACO model and they would say you know, we don't want to have all the care coordination done by the SCO, we want to do it. Let us as the provider, assume responsibility working in partnership with the ASAP and a bunch of other friends. Is that something that could happen?

SMITH: Well it absolutely can, because -- we'll go outside of SCO now. One of the biggest challenges in the fee for service world, in the services and supports that are part of the long-term service and supports, like PCA program, home health, independent nursing, adult foster care, adult help, is that it's not coordinated right now. If you're not connected with an ASAP, where you are, like I just mentioned with SCO, or if you're receiving waiver services through an ASAP, your care is absolutely not coordinated. So that would be a sea change for those MassHealth beneficiaries, to have someone from the accountable care organization look at your services, work with you, look at what's been assessed and how it could be done more efficiently and with which providers and which long-term

services and supports. That's what we don't have today but I believe is greatly needed.

BAILIT: OK. I'll share. I was in Minnesota yesterday, which is why I didn't get enough sleep last night. And their Medicaid agency is in fact talking about how do we create ACOs that integrate preventive, chronic care services and long-term services and supports, along that line. Ellen. ACOs in Massachusetts and nationally, are generally being organized by and around hospitals and physician groups. What role will nurse practitioners -- but frankly, I want to expand the discussion to other providers that are not represented here at the table, so physical therapists, chiropractors and other non-physician clinicians play, because frankly the organizers right now are not nurse practitioners or any of those other clinical groups.

BISHOP: A big part of the issue is patient choice, and so all of these providers are providers to patients and patients need to be able to have their choice to use these providers preserved. That being said, nurse practitioners are recognized as primary care providers, so patients need to be able to still have that choice. And in that, nurse practitioners need to be at the table and part of the

discussion around the business portion of health care, because we will be sharing the risk in this model. About 9 percent of all nurse practitioners that are co-owners of their practice, they are primary care providers, they carry their own panel of patients, have admitting privileges and so you know, they will be sharing the risk, along with their physician colleagues in primary care, and they need to be able to have the discussion regarding all the payment that goes on.

BAILIT: OK. I asked the panel this morning about how they think the, what I refer to as the payment within the payment, should be handled. So if a medical group or a hospital, where nurse practitioners are employed is receiving essentially a budget to manage care for a population of patients, how should the compensation, reimbursement terms for nurse practitioners and other clinicians within the practice hospital system be aligned, so that it's consistent with the quality and cost management incentives that are being provided to the larger provider entity.

BISHOP: In that scenario, nurse practitioners would be an employee, and so they would be support services in that

they're care managers. So in that regard... Sorry, I lost my train of thought.

BAILIT: It's OK.

BISHOP: So in that regard, they are -- it's necessary for there to be a definition of what a support provider is, and also it's necessary to have a definition of what a care provider is, and if there's not funding for those roles then they're not likely to happen.

BAILIT: A nurse practitioner is generally going to be compensated how when as an employee?

BISHOP: As an employee, it would be a negotiation with the organization, with the integrated care organization. That's got to be funded.

BAILIT: But today, straight salary?

BISHOP: Typically straight salary, yes.

BAILIT: OK. So, should that change so that it has quality or cost management incentives that align with the incentives being given to the larger entities?

BISHOP: Yes, because if there are incentive based programs, the nurse practitioners should absolutely have a part of that. I mean we provide very high quality care and the data needs to be collected on what is the care that we're providing, and appropriately compensated for that.

BAILIT: OK, thanks. Brian. Proponents of ACOs often speak about their being built on a foundation of patient-centered medical homes, and about ACOs being patient-centered, yet most of the discussions about ACOs, including most of our discussions with the morning panel, really seem to be more dollar centered than patient-centered. So I'm interested in your thoughts on how to ensure that ACOs are patient-centered both in their design and in their implementation.

ROSMAN: That's a great question. There is a nexus between sort of the patient-centeredness and the fiscal arrangements, and we just have to acknowledge that health care is an economic activity and the incentives, as we've talked about all of two days, the financial incentives

drive what providers do, what patients do and so on. But I think there are three things that are absolutely required in order to make it really serve the needs of patients. I'd put at the top of the list transparency. The patients need to be able to understand the health care system that they're in and how it works, and there needs to be some really open guide to what they're in.

I was talking to a Blue Cross executive a while ago, about their AQC and I said, how do patients know that they're in the AQC, and she said oh, they don't know at all, it's perfectly transparent. And I said no, no, no, that's opaque, that's not transparent at all. The patients need to know the kind of system that they're in, so number one I'd say transparency.

Number two is how do we measure quality and the pay for performance aspect of the reimbursement system. And I think it's critical, and we talked about it a little bit this morning, that we move away from strictly process measures, into serious quality measures that take into account the patient's experience of care. I think the thing that we think is most important are two things. One is look at outcome measures like preventable readmissions, preventable emergency room visits, preventable complications; things that are measurable now and that can

be used to drive decisions about reimbursement. And secondly that we ask the patients. And it's more than asking the patients you know, is the waiting room nice, did people smile at you, but really look at ways of measuring patient engagement and patient confidence, and there are tools out there that do that and we need to build that into the system. There's been good evidence that measuring patient confidence, feeding that back to the practice leads to better clinical outcomes and lower costs.

And then the third thing, and this is hard to get into, but I've called this wonk fest, so why not, is this issue of risk adjustment, which we think is absolutely critical. So there's something we have to do that's really hard and there's something we have to do that's even harder. The hard thing is to take into account not just medical claims data, but look at functional status and other things that make it harder for -- more expensive for patients to be served, so that patients with disabilities or other impairments are not -- because the provider knows that they're more high cost, and if the system doesn't know that the reimbursement won't be right. So that's tough, because we don't measure that very well right now. What's even tougher but I think crucial, is we need to figure out how to take into account socioeconomic and cultural factors

in the risk adjustment. We've talked about homelessness a lot today. A patient with an identical medical profile who's homeless, costs a lot more to take care of, and the reimbursement system, the risk adjustment needs to take that into account. We don't have really good ways of doing that, I'll be honest right now, but we need to work very quickly on figuring that out.

I was talking to an expert on this just last week and she said the most important sort of indicator really is education, and if we could somehow track patient's educational attainment and use that -- see how that affects total cost, and then go back and use that to risk adjust, we would probably account for a lot of the variation in cost. All tough stuff to do.

BAILIT: OK, but I want to ask a follow-up question, because all of your recommendations had to do with data measurement and payment, and not actually about care. I was interested in how do we ensure that ACOs, which pledge to deliver patient-centered care, have the experience that the patient has in interacting with the primary care practice, the specialist, with whomever they're interacting, that that experience is patient-centered.

ROSMAN: Yeah, no I -- that's the right question. I don't know -- I'm not going to sort of propose that we do some mandatory education program. We need to measure how well the practices are doing, feed that data back to the practice I think, and build and learn from as we go along. I know that this transition is going to be very hard and very difficult for a lot of patients and a lot of practices, and we're not going to get it right for every person in the beginning, so we're going to have to work at it. I don't -- it's a great question you're asking. I wish there was an easy answer. I don't know exactly what it is.

BAILIT: All right, maybe you'll be invited back next year and I'll be able to ask you the question again. All right, I'd like to move on to the topic of market consolidation. James, there's a great deal of consolidation that's gone on within the delivery system in Massachusetts. I'm actually going back now, more than a decade, and it's been happening in both the hospital and physician markets. We had a fair amount of discussion about it this morning and why it's happening, and in fact we had one payer representative forecast that in the end we're going to have six or seven provider organizations in Massachusetts and that's it. I'm

interested in what have been the implications of the consolidation trend for home care agencies today, if any.

FUCCIONE: Well, I mean some agencies, as a result of the consolidation and the way kind of the market has changed recently is some agencies have closed, that's just the reality of it. I think some of the smaller agencies that just have a reputation in their community and just in their community, maybe a few of the bordering towns, those have been the ones that have suffered the most, and I can name a few. I don't know if I'm allowed to. I think that's been a struggle, but the challenge going forward, like I said, with two thirds of agencies not being aligned with a hospital or health system and those being freestanding, I think that even for a Steward or Partners, that both have their own home care entities, they can't provide all the care in every community with the specialties that other agencies can. For instance, whether it's -- whether a home care agency has experience with a language speaking population. I know that Jewish Family and Children's Services has experienced serving Russian -- an elderly Russian population, and that's one thing that not a lot of agencies specialist in, but it's something that they do. So they're freestanding and there's an opportunity for them

to kind of work with a system or a hospital in that regard. There have been implications but I think it's -- like I said before, it's up to agencies to prove what they can do and kind of put a stop to it, and what we can do too, so.

BAILIT: OK, thanks. Ron, the Attorney General's Office and the Division of Health Care Finance and Policy, have both reported in the past that there is substantial price variation across providers. Harvard Pilgrim Health Care testified that such variation exists also in global payment levels, so not just in traditional fee for service payment. Do you see this variation in cardiology and what impact do you think it's having on our delivery system if any?

DUNLAP: I think there in considerable variation primarily based on the market clout, certain institutions, when the contracts for these things were initially negotiated. There was a payment form panel, that after Martha Coakley's disclosure, that looked at eight measures for trying to level the playing field. One of which is disclosure, in terms of what it could cost to do a gallbladder at hospital A, B, or C. They thought that would be effective. Rate setting, they felt would not be effective, but they more or less have tried to narrow the bandwidth between payments so

that adjustments would be made for teaching hospitals who also provide different types of care. But overall, they would try to limit the bandwidth between what the highest and lowest got, and try to center everybody around the mean so that the payments would be more fair. So that has been effective.

On certain payments, there's a 300 percent differential. I can do a consult on a MassHealth patient and get a third of what a Partners doctor can get, in the old system. So that's problematic in terms of trying to manage a challenging population like that, where the margin is razor thin. So I think that that's all being looked at, but there are only two or three of the eight that seem to be reasonable, that they did not feel that they really could negate market clout in terms of making that adjustment. I think you see on the health care reform, there are various formulas, but they all pretty much deal with the gross. The Governor is fascinated with gross state product and whether it's minus a half percent or whatever, they want medicine to track the general economics of the state.

BAILIT: What do you personally think the state should do in order to reduce variation in prices?

DUNLAP: I think the analysis of the care and adjustments for what various hospitals do. There are definitely services that some hospitals provide that don't make them any money but give them more of a global service orientation, but I think we have to make it fair for everyone. I think there are clearly specialty services that are provided only by certain people, that's a different area. But if you're treating a pneumonia and you're doing it well, the compensation for that, wherever the venue, should be the same or close to the same.

BAILIT: OK, thanks. Ellen, to what extent does variation in hospital and physician prices influence the distribution of nurse practitioners in the Commonwealth?

BISHOP: I think the key there is how nurse practitioners are recognized within the system, and I'll speak specifically to tiering within the reimbursement issue. We've had experience in the past where nurse practitioners were tiered as specialty providers, so that -- as opposed to a primary care provider, so that it would cost the patient more to see a nurse practitioner than it would to see a physician. So in that respect, we just need to make sure

that all of those definitions and those placements are appropriate so that we are being reimbursed for the care that we're providing, but then the patients also are not being adversely affected by the classification of where we're listed within that structure.

BAILIT: Is there a battle among provider groups and hospital systems to hire nurse practitioners, where those that are receiving higher rates from insurers or from the state or from wherever, are luring away nurse practitioners from other providers that have lower rates?

BISHOP: I haven't seen that happen. I mean, I know that there are some larger institutions that have recently had a large hiring influx of nurse practitioners, but not in the sense that -- not in the reimbursement sense.

BAILIT: OK. I ask only because in past meetings I've had with members of the medical society, they have talked about that happening for physician specialties. I'd like to turn now to talk a little bit about tiered and limited network products. Brian, what are the implications of these products for low income consumers?

ROSMAN: Yeah, so we get a lot of calls on our help line, which gets about 40,000 calls a year, from increasingly in the last few months, particularly last year, is GIC members switched into tiered products. We started getting lots and lots of calls and we had two reactions. One is people didn't understand them. They don't understand what this is and you know, all of us who follow this stuff so closely, don't understand disconnected people are from their care. They may have gotten notices in their paychecks and stuff like that. They didn't understand it at all. So then we would explain it to them and then when we explained it to them they didn't like it, they didn't like it at all. So they didn't understand it and when they found out about it they didn't like it.

There was just a survey that came out today, polling Massachusetts residents, and they said would you be willing to accept limitations on your choice of provider if it meant lower costs for you? And the people surveyed, 57 percent said no way, and only 19 percent said they would be willing to limit their choice if it meant a 20 percent cost savings. So I think people -- and I was glad to hear the discussion this morning about tiering being kind of a weigh station to something better, and we really hope it is. We really see it as a forced response to a problem that has

much better solutions. We know for people caught in examples of two doctors in the same practice, two different tiers, or a specialist that they're referred to being in a different tier than the one they see, or not being able to find out which tier a particular provider is going to be in before they go. All these issues we need to deal with.

BAILIT: So what are the much better options?

ROSMAN: The much better options are to orient our system so that one, there's a care coordination and care management, is the top of the list. And we can use our resources to reduce the unnecessary cost from repeated tests, from unnecessary procedures, from more focus on acute care and less focus on prevention and primary care.

BAILIT: So this is a great segue to my next set of questions. When I was in Minnesota yesterday, there was a legislator who was participating in this taskforce and he said all right, but what about the patients' end of the bargain, what about patients responsibility and accountability? We shouldn't put this all on the shoulders of providers, that they've got to make everything happen. Patients have responsibilities too. So, I'm interested in this idea

about patient engagement and activation. Ken, I'll share, not only did I hear that from the legislature, but I've heard providers complain, why is it all on us? We've got to have incentives and engagement for consumers to become better at self-care, at taking their medicine. What information and tools do you think consumers need to participate fully in their care?

SMITH: They have to be aware of all their options, first of all. I think we, as a state government entity, have some shared responsibility to help the consumers out there, the patients, with all the education. At Elder Affairs, we have something called SHINE, Serving Health Information Needs of the Elders. They receive hundreds of calls a day and a lot of what they do is counseling with elders, as far as their options and how they can exercise their options and what choices they have. In addition, the -- I want to go back to SCO and PACE for a minute because I'm so proud of them. But with both those programs, we have advisory councils, and the consumers that we support come in, and they come in to Elder Affairs and they sit at the table with us, and with the SCO plans and with some of the ASAPs, the Aging Service Access Points. And we listen to them and we listen to what some of their frustrations are or where

they have been pleased with having made the choice and being aware of the choice to go into a SCO program, a PACE program, or in some cases people choose neither and choose to be part of the frail elder waiver, which is also a coordination of care and services and supports for the elderly. There are so many options out there and people aren't aware of them.

I was also speaking with nursing home residents recently, about the Money Follows the Person, and people just, they were empowered with that information, that there would be this grant that they could be enrolled in, that would help them with both housing searches and setting up the supports and services they would need to transition from institutional care to community care. So yes, I think that MassHealth members, the patients out there need to be at the table, they need to be exercising choice, but they can't if we're not at the table with them and sharing that responsibility of educating them.

I also want to talk about the options counseling and the CSSM program that we have at the ASAPs. These help individuals who are in institutionalized care to learn more about their community options, that they do have the choice and these are the programs that are available to them. It also talks about cost and cost of health care, and it helps

them to understand that these options are available out there and this is what their life could be like choosing those options, living in the community and having adult foster care and adult habilitation and some of my other programs. But they also can understand what they might give up. A lot of times people living in nursing facilities or chronic rehab hospitals or other institutionalized care, do really look at what they have as coordinated care. All their needs are met at the nursing facility, with the exception of sometimes having to be sent to an ER. So I think that again, we have to really help them to empower them, so that they can do more self-directed care and making their own choices.

BAILIT: James, same question for you. What do we need to do to activate consumers or patients to participate fully in their care?

FUCCIONE: I can understand the provider perspective that you know, they feel like it's all on them to educate, but I think it's on everybody. It's on -- the consumer has to have the responsibility and need to know more, I mean the providers, trade associations, state government and so on. I think it's going to take the whole team to -- you know, a

village to educate the patients. I think it's going to take everybody, whether it's the options counseling and other programs like Ken was talking about, or whether we really try to focus on patient choice. We're just talking about market consolidation but even with consolidation, there are still choices in procedures and even home care and what have you, on what patients can access.

BAILIT: All right. Ron, I'd like to ask you because South Shore is managing against a budget with Blue Cross, for the AQC contract. The feedback from Ken and from James has been about informing people about their choices. That's a little bit different than informing them about their responsibilities for self-care. If and when you get that ideal information system, you'll see that 50 percent of your patients aren't filling their prescriptions at a schedule that indicates that they're complying with their medication regimen, for example. And I think we all know that research shows that the predominant cause of early mortality is health behavior, and that in fact the health care system has little impact on early mortality. So, I'm interested in your perspective. You've been given a budget, you've got to manage to it, and yet you have patients who aren't exercising, they're obese and they're

not taking their medicines. What's your perspective in terms of the responsibility of the patients and how should they be engaged?

DUNLAP: I think medical literacy is whether patients know about their disease process, whether they understand their medicines and so forth, and the estimates are that only about 10 percent of us are medically literate. So that means that even across educational barriers, 90 percent of the people don't truly understand what their disease process is and why they take certain medicines. They may have a list of ten medicines but they can't -- when you've done a good job, they can tell you this one is for my blood pressure, this one is for my heart failure and so forth. But when they just say I take these ten medicines and I do what you say, they do take those ten medicines, but I had a patient come in this weekend and I said, have you been good with your salt, et cetera. Yes I have. And then I had the heart failure nurse practitioner sit down with her. She had nachos, she had this, she had that, all high sodium, and went out to dinner. I try to personally educate my patients about the salt in the restaurant, that it's three to five times your daily requirement.

So that we really have to put some emphasis on patients, but it depends on the patient population. At the low end, some of the most successful programs have been community based initiatives, where churches or various community agencies which know the language, know the culture, have sent workers into the neighborhood to reach people. And when you're looking at MassHealth, those types -- I've seen some impressive projects in New York, there's an impressive project that a young woman has done in Framingham, with Hispanic speaking people, to cut the readmission rate, to have them understand the message. But many times it's somebody who understands their cultures and communicates, and it's not a high dollar -- it's not a nurse practitioner, it's a community worker, it's a health coach type person that's a family member, that's now educated.

So the issue really is with the low budget payments, how can we reach more people? The thought is that sometimes we would perhaps instead of talking one-on-one with a patient, meet with 20 patients or telemedicine. There are other ways of trying to deliver the information that I may give a patient one-on-one, which my office manager hates me because I take more time and I probably don't charge for it, but once those patients understand,

they're more likely to do what is necessary. But to a certain extent, they have to have some skin in the game. The problem is at the low end you can't penalize, and so the health care plans have looked at this and they really can't penalize, but they are looking more at OK, if you keep your weight down, you get $150 health care credit. My wife gets that for going to Curves and exercising, so that positive benefits seem to be one mechanism where we can do stuff. But penalizing people is probably not in the cards, but that really -- I think if you had some risk exposure, you would behave differently.

BAILIT: OK, thanks. Any questions to my right or from the audience?

BOROS: So there's actually a follow-up question on almost exactly the same issue, about information. There's a growing amount of information available to consumers about cost and quality, but the evidence that a large group of consumers is using that information is relatively weak, and it doesn't appear that it's growing particularly rapidly. And so what needs to change about either the kind of information that's available, or something else about the need to use information or the incentive to use

information, for consumers to have -- to be really more engaged at that information level. The questioner directed that question to Brian but I'm sure there are others who might want to weigh in.

BAILIT: We'll let Brian go first.

ROSMAN: It's a real problem. The information that's out there, we've worked a lot on trying to improve it, and the Division has been part of that, and the QCC, and yet we find it's still difficult for people to look at. And it's not clear exactly when people look at it. A lot of -- I remember hearing Charlie Baker talk again and again and again about comparing hospitals when your woman is about to have a baby, and I thought you know, that's one of the few examples where you have lots of lead time and lots of incentive to look up the ratings and compare. A lot of health care is you find out today that I've got to go to the hospital now, or you're involved in a relationship, a long-term chronic disease relationship where you have little incentive to switch providers in the middle of the stream once you get into it. So we need to find ways of making it more accessible and working with patients on health literacy, like Dr. Dunlap said, but I think there's

limits to what we can accomplish with this kind of information.

BAILIT: Go ahead Ron.

DUNLAP: To a certain extent, I think a lot of this is generational. The younger people are more likely to use their -- I mean this weekend I was on call and before I went to see the patient the nurse said, by the way she Googled you, she checked out your credentials, she saw what your affiliations are and so forth. So before I even went into the room, I was almost on the defensive, but the person -- but she said she was happy. But that's really somewhat intimidating, but that looks like part of the future for certain segments of the population, that the younger kids, with all their access to information, are probably going -- and that's not the first time that's happened, that patients have looked up. Before it was word of mouth, you know you took care of my neighbor, you take care of my mother in-law and so forth. When you're in a community for a while, that worked for you, but in talking to Delores Mitchell about tiering, there's no evidence in my mind that the patients have used tiering as a way to decide which doctor they go to see.

BOROS: Can I actually follow up on that point. If a patient were to, before they meet you, as they're selecting a physician, Google you or look up, what information do you think a patient should be making that choice based on? So right now the information, if they just look on your website, they'll see your credential and your education, things like that. That gives you some kind of information. The QCC website would not for you individually as a physician, it doesn't help at all, but it might give a sense of your practice or your affiliated hospital. So what information should a patient be using to choose a physician?

DUNLAP: I think the actual true information other than credentials is quite limited.

BOROS: But let's say it's available, whatever they need is available, what would it be?

DUNLAP: I'll give you an example. A person that's considering a joint replacement, comes to me and says, I want to have my hip replaced, what are my options? And I say well you can come to South Shore Hospital, there's the New England

Baptist. Patients, to a certain extent are aware. Now some of those -- again, you go to the website. I mean, I had to choose an orthopedic surgeon for my daughter in-law and I used the websites for my own personal information and so forth, to look at the training of the people that I was going to refer her to. I know some of them, but I was also looking for somebody specific, and I was able to use that information to decide. But I think the average consumer doesn't have enough background knowledge to use that data the way I can use it.

BAILIT: I'll add, just by coincidence, I happen to have a family member who is having spinal fusion surgery today in Massachusetts. I did lots of research in advance and there's no available information to let him know which hospital and which surgeon is best to do that surgery.

BOROS: So let's set aside what's available today. What would we want to be available? I mean is it just outcomes measures about mortality and morbidity and functional status and based on a particular physician? And then you get a star rating based on your outcomes measures, or is there some other patient experience measure that we would

prefer? So I'm asking the physician on the panel, what do you want to be chosen based on?

DUNLAP: I think this is going to be more systems based than it's going to be on individual providers. In other words, you know I went to a lecture on the top seven orthopedic hospitals in the country, and they had developed a system to cut their infections, to handle the rehab process, and it's a cookbook thing. And to a certain extent, when that all goes perfectly, they were actually able to eliminate the doctors. But I challenged them, I said when something goes wrong, you need to have a physician who understands that patient and knows the risk. I think we're going to see more institutional tiering and more evaluation of groups, so that your whole network... In other words, when I talked about that experience of a patient having a knee done, across a whole range of services, they're going to be looking at your entire system and what the effects and experiences in your system. So that's, I think going to be more of an issue, rather than looking at individual providers. So we're all going to be on -- all of us, on a team, and they're going to be looking at our team outcomes, just like the way people say the Patriots have a great

organization, that's the way your health system is going to be looked at.

SMITH: And I was going to mention just Health Care Compare on cms.gov, that has home care compare, hospital compare, physician and you know, like Ron was saying, now it's by each provider but soon it will be by the team and the group of providers. So I think we could do a better job of promoting that tool on cms.com and the mandatory reporting that providers have to do, but in the future that's where it's going I think.

BAILIT: Thanks. Ellen.

BISHOP: From a primary care perspective, I think it's important for patients to have a full listing of the various type of providers and their scope of practice definitions, so that they can get the maximum value out of the system.

BOROS: We have another question here about consolidation, and this goes to some of the conversation we've already been having. The question says, there seems to be a negative tone around consolidation, but doesn't it seem that

consolidation would allow for better care coordination and population management? So where do you fall in that balance?

ROSMAN: Just real quickly, I think for a lot of patients, they're really oblivious to it and not too concerned about the corporate structure of how they get their care, and whether hospitals are aligned together or not is really doesn't enter into the care picture. They're interested in how their care, what it costs, and the quality of the care they're getting. So I think that's right, if we can consolidate around improved care and keep prices down and keep cost down, I think there's nothing wrong with that. I don't think we're all, I think focused so much in the long-term, it's what the care is actually like and not the sort of corporate organization based on who's investing from where and what.

DUNLAP: I think the problem with the process is that it's very expensive. So in order to consolidate and bring people together, the cost of doing that -- I mean in the South Shore, they're looking at in the hundreds of millions of dollars from different systems, competing to try to become dominant in the market. So, once I'm going to invest in

you to that extent, when we're going to be the worker bees, we become just a cost center. So there's a lot of concern from the physicians and providers as to how they will be squeezed and always be the whipping boys or girls for the cost savings. And when you really -- when they're looking at this cost escalation in medicine, I've asked the panel that's looking at that, to break that down by segments. Let's look at the hospital, let's look at the technology portion. The rapid increase is not really the providers, there are other issues in the system, and some utilization issues. So the fact that it costs so much money, because we're in such a competitive environment, is what's driving some costs.

When you turn on the Celtics and you see X, Mount Auburn and Steward, and all those -- those ads cost money. In New Hampshire, by law, when you do your statement for finances, you have to show how much of the dollar goes directly to patient care. That number is in the 45 percent range, but because you can't have your accountant cooking the books. In Massachusetts, they claim 85 to 90 percent. Now we know that when you look at all those ads and all these other issues, there are a lot of expenses just because we're in a competitive environment. So that's driving cost and that in turn, if you're a small business

person and you start talking to venture capitalists, once you take their money you lost control. So the issue nationally for the patient, for doctors is governance. Will we have a say in how things are done and will we be happy in providing care in this new system and can we provide better care or will we be pushed to see twice as many patients per day and maybe our care and quality of life and the happiness of our patient goes down. So that's the fear of a large corporate entity, not the fact that we have to consolidate into larger groups, which if physicians had more vision, they would have done a long time ago on their own.

BOROS: So can I follow up on -- I think it's a follow-up on this issue of highly integrated -- I'm sorry, highly competitive environments. You have a lot of experience with health information systems and you also mentioned earlier that in your market, there isn't a dominant player. Do you see that reflected in a lack of interoperability and sort of what do you see as the existing state of interoperability of health information technology and electronic health records and sort of what are the next steps.

DUNLAP: For a reason, our hospital has been relatively progressive, so they have worked with for instance, Atrius. I can see into the hospital system from the web, from my home or from my office, on my desktop computer, or from my phone. So I can look up -- when a patient calls me at night on call, I can look up their lab result, where I couldn't do that before. The hospital has facilitated moving information electronically from their facility to us. We unfortunately can't send that data back. Except for Atrius, I could actually look into the system and see your record, your allergies, your medicines and so forth. So to a certain extent we're way ahead of the state in terms of some degree of interoperability, but there's the technical aspect of connectivity and there's the politics of connectivity, and the politics of connectivity is what gets in the way of us sharing information.

BISHOP: I'd like to follow up on that. I work in a very different environment, I'm not in a hospital setting, and getting information on my patients is a huge challenge. You send them off to specialty care if they're admitted to the hospital. It's very difficult to get some of that documentation and so that you can appropriately care for your patients.

BAILIT: Do you have an electronic health record in the environment that you regularly practice in?

BISHOP: I do, yes.

BAILIT: Is it an interoperability question or is it a political question, about just building the bridges? So is it technical, is it political, it is just a way of doing business that's the barrier?

BISHOP: I think it's technical more than anything else, and having the various types of electronic medical record systems be able to talk to each other appropriately, because right now most of it happens by fax and scanning, and it just slows the process down, you know if you can even get the fax. So I think it's more of a technical issue, from my perspective.

DUNLAP: Even with electronic medical records, in the past as specialists, most of what we got back was labs from the primary care physicians, and never got a note. Another specialist might send me a note, always hand a dictated note to the primary care doctor. Now that they have

electronic -- we get a fax of their electronic medical record, but we don't get an electronic sharing. In some cases we have people with electronic medical records. We actually have a system where we have transcription, so we transcript and it gets emailed, so that my consult is available within half an hour of the time I do it. We've done that for large systems like Atrius, where they needed a better turnaround. But the lack of ability to -- we can move things through the central node, which is the hospital, but we can't move them around the horn, between practices, so that's a huge problem. So I think that unfortunately, some of us were put on this MeHI advisory panel, but we were put on when they were almost completed with the project. There was no physician input early on, and I think had we had something to say early, we would have tried to push for a community initiative, which is to have a linked community. What's going to happen is as systems consolidate, instead of 400 electronic medical record vendors, we're going to have fewer, and the consolidation is going to take part of the problem away, but the small practitioners are going to be very dependent on the state health information exchange.

WU: A follow-up question for Brian. On the point about consolidation, you had described many consumers aren't aware, they're not paying attention to whether a provider is corporately integrated, and corporate integration, as long as it's driving toward coordination that's a good, if it isn't driving up costs. Dr. Dunlap responded with a couple of examples where that dynamic can end up resulting in higher cost. So from your perspective, what metrics does the system need in place to ensure that any type of corporate organizational integration is driving towards that greater efficiency that you think would benefit patients, as opposed to just higher costs?

ROSMAN: I think we need substantial government oversight. I don't think we can leave the market to itself and allow the corporate comings and going to just happen based on cash flow needs and sort of corporate imperatives. We need a stronger -- I think the health plan provisions of both the Governor's bill and the House and Senate bills are really important. We need to have a plan for the state, on what kind of facilities we need and where we need them to be, and that the DON process needs to be integrated with the planning process. I think we need more power. We talked about the Attorney General's role and state government

role, in some sort of public accountability for what the health entities are doing, and an approval process where the public has a role and some input and that public interest is taken into account. But in the end, I think your question you ask is very difficult to answer and there's no easy solution.

MassHealth, for example, has a single carve out we just heard about, providing all the mental health benefits for the entire PCC population. That's a -- there are benefits consolidation there that seems to work quite well. We're looking at the Duals project, where they're looking at a number of ICOs that we're hoping to attract, because they're hoping the competition provides better services. We are not sure how that's going to work.

DUNLAP: One thing I think might help is that the driving force for bringing cost down is primarily coming from the business community and the fact that employers really want to lower their costs. So the issue is with plans offering tiered products and so on, is to have some uniformity in what's offered, so that a patient or a consumer can look at what they're getting and what they're not getting, because this is a very -- when you look at these plans, when you get your open season little card to look at, it's very

complicated. And so I think simplifying that process and putting right out right in a uniform manner, so you could have a table to look at the five plans to see, am I getting this covered, what am I losing, what am I gaining, would really be important for the consumer. Because I think the consumer wants the best care and although they're concerned with cost, they really want the best care. The employer is looking at this is costing me a fortune, I want to lower my costs. And so there has to be some sort of way of not only looking at what's offered, but in the final analysis also, looking at the end once we develop that data, as to who has the best quality. So value is quality over cost, so that it could cost you more to go to one institution, but if their infection rate is lower and their outcomes are better and so forth, they're delivering a better value. That's a very difficult thing for us as physicians and medical professionals to evaluate, much less the consumer at this point.

Concluding Remarks

BOROS: Great. Thank you very much. I really appreciate everybody's contributions today and with that, I will be closing the second day of the 2012 cost trends hearings. I

want to thank our panelists who took time out of their busy days to contribute to this conversation about the impact of consolidation and the opportunities of care coordination and the new -- version 4.0 of health care reform. We'll be rejoining the conversation tomorrow morning at 9:00 for public testimony. We encourage you to come at 8:30 to sign up for public testimony before the event begins. With that, I want to thank Michael Bailit and my colleagues here, Rob Whitney from DOI and Karen Tseng from the Attorney General's Office, and we will see you again tomorrow. Thank you.

END OF AUDIO